Pediatric Partners, PLC
4649 N Breton Ct SE, Suite A
Kentwood, MI 49508
Phone 616-656-8600 Fax 616-656-8601

AUTHORIZATION FOR RELEASE/RETRIEVAL OF MEDICAL INFORMATION

Patient Name_____ **Date of Birth**_____

Address_____

_____ **Telephone**_____

_____

RECORDS MAY BE RELEASED TO:

_____
_____
_____

I AUTHORIZE PEDIATRIC PARTNERS, PLC TO RELEASE/RECEIVE INFORMATION CONTAINED IN MY PATIENT RECORDS, INCLUDING, AS APPLICABLE:

Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health Regulations, which include Venereal Disease, Tuberculosis, Hepatitis B, HIV, HIV test, AIDS, and AIDS related complex (ARC) and _____ (specify if known).

Alcohol and drug abuse treatment information protected under the regulations in 42 code of the Federal Regulations, Part 2.

Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

INFORMATION REQUESTED

_____
_____
_____

PURPOSE OF DISCLOSURE

___Continued Patient Care ___Attorney/Legal ___Insurance ___Other_____

It is further understood that the information released is for the purpose stated above and may not be provided in whole or in part to any other agency, organization or person. I further understand that correspondence, patient discharge instructions and records from other health care providers will not be released with this routine request.

This consent expires six months after date of signature.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Witness (second if signed with an X)