AUTHORIZATION FOR RELEASE/REQUEST OF A CHILD'S PROTECTED MEDICAL RECORD
(One Form Per Patient Record)

Today's Date: _____

Patient FULL Name: _____ Date of Birth: _____

Name of the Person and relationship to the patient making this request:
FULL Name:_____ Date of Birth: _____

Address: _____ City: _____ State:_____ Zip: _____

Contact Phone/Cell: _____Relationship: _____

As the biological parent or guardian of the patient identified above, I authorize (Office Name) _____ to disclose or provide protected health information about my child:

TO:

Facility Name: **Southside Pediatrics** Facility Phone: 269-818-1020

Address: 300 Meadow Run Drive Facility Fax: 269-818-1266

City, ST, Zip: Hastings, MI 49058

Provider Name: _____

Transferring Provider Office Information:

Facility Name: _____ Phone:_____
FULL Mailing Address:_____
Provider Name: _____
FAX:_____

Purpose of Medical Release: * Fees may apply if the record exceeds 50 pages or more.

	Transfer of Medical Record		Coordination of Care
	Insurance Claim		Litigation
	School Release		Referral
	Personal- As requested		

Release Method Requested: _____ Paper/ USPS Mailing _____ Fax, provide # ____ - _____ - _____

Other: _____

Please check or specify requested information below: Dates From _____ Dates To _____

	ALL Heath Information		Medical Summary		Immunizations
	Lab Reports		Sick Visits		Well Child Visits
	Growth Charts		Hospitalizations		Imaging Reports
	ER/Urgent Care		Allergy Shots Schedule		Behavioral Health
	Sexual Health		Alcohol/Substance Abuse or Treatment		

Note: We will process your request as quickly as possible. Some records are stored off site in a secure facility. Please allow 60 days for the collection, copying and mailing of your child's medical record.

Conditions:

1) I understand that the health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS) and or human immunodeficiency virus (HIV). ***If I don't want these to be released***, I will place a check mark here: _____

I don't want the following records released: _____

2) I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

3) I understand that information used to disclose pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read the above foregoing Authorization for Release of Medical Record Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ Date _____

Signature of Patient/ Parent/ Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

_____ _____

Print Name of Authorized Representative Relationship/Capacity to patient

_____

Address and telephone number of authorized representative

This authorization will expire (120) days from the date of my signature, unless I specify otherwise.

_____ DATE: _____

300 Meadow Run Drive, Hastings, MI 49058
(269) 818-1020 (269) 818-1266