Grandville Pediatrics

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P# 616-538-2410
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient name_______________________________________ Date of Birth___________________________

Address____

Telephone#____

Records may be released to:
Grandville Pediatrics
2845 44th St Suite 200
Grandville, MI 49418

From:
____
____
____
Phone#____

I authorize Grandville Pediatrics, PC 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 Dept. of Public Health Regulations, which includes Venereal Diseases, 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 code 42 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:
_______All records, including specialist reports and previous records
_______All records, except:____
_______Other: specify____

Purpose of disclosure:

______Attorney/Legal ______Insurance ______Continued Patient Care ______Other

It is further understood that the information released is for the purpose stated above and may not be provided in whole part or in part to any other agency, organization or person. I may revoke this Authorization at any time by notifying Grandville Pediatrics in writing at the address listed above. The revocation will not be effective for information that Grandville Pediatrics discloses between the time that this Authorization is signed and when the revocation is received. I understand that the persons to whom information is disclosed under this Authorization may possibly redisclose the information to others without my knowledge or consent, and therefore, the privacy of my personal and health information may no longer be protected by law.
This Authorization will expire one year from the date signed unless an expiration date is listed. Expiration date______________________.

____
Signature of Patient or Legal Representative Date

____
Relationship to Patient