REQUEST FOR RELEASE OF MEDICAL INFORMATION

I authorize ____________________________ (Healthcare provider)

____________________________ (Address)

____

____________________________ (Phone number)

____________________________ (Fax number)

to release certain protected health information (PHI) about my child/ren listed below including any which may relate to:

The information to be disclosed from medical record:

*specific dates of service (list specific dates or event): ____________________________

*entire medical/vaccine record: ____________________________

*last checkup/vaccine record: ____________________________

*other (please state reason): ____________________________

Purpose of this request: ____

This information is being released for the specific purpose stated above. I further understand that records from other healthcare providers will not be released with this request, nor will this information or record be made available to any other person or agency unless another authorization is obtained. This consent can be revoked in writing, except in those circumstanced in which the information had already been released. I understand signing this form is voluntary and I do not need to sign this form to assure treatment. When this information is used or disclosed as requested by this authorization, it may be subject to disclosure by the recipient and may no longer be protected by federal HIPAA Privacy Rule. This authorization will expire 3 months from date of my signature or upon completion of forwarding records to named party.

Child/ren:

____________________________ ____________________________

Name **Date of Birth**

____________________________ ____________________________

Name **Date of Birth**

____________________________ ____________________________

Name **Date of Birth**

Forward records to: Northpointe Pediatrics, PC
30061 Schoenherr Suite A
Warren, MI 48088
Phone # 586-558-2111
Fax# 586-558-3665

__________________________________ __________________________________ __________________

Print Patient/Parent/Guardian Name **Patient/Parent/Guardian signature** **Date**