PEDIATRICS,P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The below is to ensure your right to privacy. Please complete in its entirety.

I authorize ______________________________ to release the following medical
(Name of physician/facility)
information regarding ____
(Patient's name on record)
Date of Birth__________________ Social Security #______________________________

To: Pediatrics, P.C.
670 Mall Drive
Portage, MI 49024

(Please initial appropriate line)
__________Any and all of patient's medical records (as of the date of this release) or
__________Send specific records listed below:

____

____

This release also specifically allows the release of the following information (this information will be released unless the appropriate line is initialed):

__________Any record of treatment for drug and/or alcohol dependency or abuse;
__________Any record of mental health treatment;
__________Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This information is being released for the following purpose(s) only: __________________

__________________________and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective for one (1) year from the date of execution; however, I may revoke it at any time by providing notice in writing to the above named party.

________________________________ ____________ ______________________
Patient/Legal Guardian Date Phone Number

________________________________ ____________
Witness Date