AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION TO WESTERN MICHIGAN PEDIATRICS

The Undersigned hereby authorizes and requests that _____
Name of Physician or Organization

_____
Address, City, State, Zip Code

_____ _____
Telephone Number *Facsimile Number (if known)*

disclose the protected health information of:

_____ _____
Patient Name *Date of Birth*

To Western Michigan Pediatrics, PC

___ **Grand Rapids Location** **Phone:** **616-949-6112** **Fax:** **616-949-8530**
___ **Jenison Location** **Phone:** **616-457-3510** **Fax:** **616-457-4660**

Protected health information to be sent:

____ Entire medical record, except information that Western Michigan Pediatrics, PC, may not release by law, or by policy of the practice, such as records of drugs and alcohol abuse program treatment, mental health treatment or HIV or sexual abuse information.
____ Other:
_____
_____

Purpose:

____ The patient is transferring to Western Michigan Pediatrics, PC

I am:

____ The patient.
____ An authorized representative of the patient (please provide proof of authority).
____ A parent of a patient who is under the age of 18.
____ The legal guardian of the patient (please provide proof of guardianship).

_____ _____ _____
Signature *Printed Name* *Date*

I.E.2
Adopted April 14, 2003
Revised July 10, 2017