western michigan PEDIATRICS

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).

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time

_____ _____ _____
Signature *Printed Name* *Date*

Adopted April 14, 2003
Revised July 10, 2017
Revised May 16, 2018