Medical Information Release

Jackson Pediatric Associates

I AUTHORIZE AND REQUEST the release of the specific information below for the patient listed here:

Patient Name: _____ Date of Birth: _____

AUTHORIZED BY: (Patient, Parent or legal guardian) AND; I am authorized to make this disclosure:

Name: _____ Date of Birth: _____

Phone: _____ Relationship: _____

RELEASE FROM:

Name: _____

Address: _____

RELEASE RECORDS TO:

Name: _____

Address: _____

INFORMATION TO BE RELEASED:

Dates of Service: _____ through _____

_____ Specifically my entire medical record **including**, Substance Abuse, Mental Health, HIV related testing;

_____ Specifically my entire medical record **excluding**, Substance Abuse, Mental Health, HIV related testing;

_____ Other: All relevant medical, inpatient, and diagnostic testing records

_____ Specifically Only _____

PURPUSE OF DISCLOSURE: *Please circle one*

Relocating out of area Changing doctor in area Specialist Consulation/second opinion

Transfer from pediatric to adult doctor Legal School Insurance Change

Workers Compensation Medical Care Billing Information Other: _____

1. I understand this authorization shall be effective following the date of signature, A photocopy of this authoriztion is valid.

2. I understand that is the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer proceted by these regulations. An exception for registered substance abuse and chemical dependency clients applies. See notice below.

3. I understand that I may revoke this authorization at any time by notifying the providing oranization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. This authorization is in effect until it is revoked by me or until it expires under applicable laws.

4. An exception for registed chemical dependency and substance abuse patients who are involved in the Criminal Justice System when the consent is a condition of parole, probation or release from confinement applies. In these cases this consent may not be revoked at any time unless there has been a formal and effective termination or revocation of such release from confinement, probation or parole.

5. I understand that in compliance with the State of Michigan laws pertaining to record copied, I may be charged a base fee of $ _____

6. I authorize this information to be sent via fax transmition or email at my request.

_____ _____

Signature of patient OR parent/legal guardian/authorized person Date

2100 4th Street Jackson MI 49203 517.787.4330 Fax 517.201.4186