

Trestlewood Pediatrics
Authorization for Release of Medical Information

I, _____ authorize Trestlewood Pediatrics to release the following medical information to _____

Patient Name _____ Date of Birth _____

- Any and all of my medical record (as of the date of this release)
- Immunizations only
- Any and all of my medical record **except** the following _____

Please initial below if you want the following to be released. This information **will not** 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 other immune disorders.

This information is being released for the following purpose(s).

- Relocating and transferring outside the Kalamazoo area.
- Transferring to an adult doctor in the area (patient has outgrown pediatric age).
- Seeing a specialist.
- Insurance company request.
- Transferring to a new pediatrician due to dissatisfaction related to one or more of the following:
 - Convenience of the office location
 - Waiting time in office
 - Pediatrician's care of child
 - Nursing staff
 - Interactions with other staff
 - Difficulty scheduling timely appointments
 - Change of insurance. If so, please list new insurance _____
 - Other (please comment below) _____

Other _____

This release is effective for six months from the date of execution. However, it may be revoked by me at any time by providing notice in writing to the above named party, but that the revocation will not apply to information already released based on this authorization. I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules. I understand that authorizing the disclosure of this health information is voluntary. I understand that I will be responsible for fees incurred for processing this request as per laws of the State of Michigan.

Signature _____ Date _____

Office use only: ___/___/___ Date information released Initials _____