Trestlewood Pediatrics
Authorization for Release of Medical Information

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

to: ___________________________________

____

____

Patient Name ____________________________________ Date of Birth _____________

____________________________________ Date of Birth _____________

____________________________________ Date of Birth _____________

____________________________________ Date of Birth _____________

___ Any and all of my medical records (as of the date of this release)
___ Records before 2012 (additional charge of $25.00 to pull chart from archive)

___ Immunization Only

___ Any and all of medical records **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 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
- ___ Interaction with other staff
- ___ Difficulty scheduling timely appointments
- ___ Changes of insurance. If so, please list new insurance ______________
- ___ Other ____

I understand that I will be responsible for the fees associated with the medical records request as per laws of the State of Michigan. 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 the 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 the health information is voluntary.

Signature _____________________________________ Date _________________

Office use only ____/____/_____ Date information released Initials __________