TRESTLEWOOD PEDIATRICS

Robert B. Page, M.D., F.A.A.P.
Stephanie Somers, M.D., F.A.A.P.
Anthony J. Van Es, M.D., F.A.A.P.
Rebekah Lampart, D.O., F.A.A.P.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize use and/or disclosure of the named individual's health information as described below

Patient First Name	Patient Last Name	Date of Birth
Street	City/State/Zip	Telephone #

Send Records to:

Trestlewood Pediatrics
5082 Lovers Lane
Portage MI 49002

Request From:

_____
_____
_____
_____

Treatment Days:	Purpose of Request (not required):

The following information is to be disclosed:

- ☐ Immunization Record
- ☐ Physician Notes
- ☐ Information for school/work absence
- ☐ Lab results
- ☐ X-ray reports
- ☐ MRI scans
- ☐ Cardiac studies
- ☐ Complete record
- ☐ Other _____

I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for disclosure and that the information then may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition. (If I do not specify an expiration date, event, or condition, this authorization will expire in one year.

Signature of patient or legal representative	Relationship to Patient	Authorization Date