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 RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, authorize the release of Protected Health Information for:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Trestlewood Pediatrics shall release the information to:

Name of Individual or Agency: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Trestlewood Pediatrics shall release the following information:

☐ 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 ☐ Seeing a specialist

☐ Transferring to an adult doctor in the area (patient has outgrown pediatric age) ☐ 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 _____

5082 Lovers Lane • Portage, MI 49002 • Phone: 269-381-0118 • Fax: 269-381-4610 • www.trestlewoodpediatrics.com