

Authorization to Release Medical Records

Use this form to have records sent to this practice, or from this practice to someone else. One form per child, per direction.

PATIENT

CHILD'S FULL LEGAL NAME

DATE OF BIRTH

ANY FORMER NAME ON THE RECORD

STREET ADDRESS

CITY

STATE

ZIP

WHICH DIRECTION

☐ Send records TO Belleville Lake Pediatrics☐ Send records FROM Belleville Lake Pediatrics

THE OTHER PRACTICE OR PERSON

If records are coming to this practice, this is the office that has them now. If records are going out, this is where they should go.

PRACTICE, HOSPITAL OR PERSON

ATTENTION, IF KNOWN

STREET ADDRESS

CITY, STATE, ZIP

PHONE

FAX

EMAIL OR PORTAL, IF USED

WHAT TO SEND

- | | | |
|--|---|---|
| ☐ Complete medical record | ☐ Immunization record | ☐ Growth charts |
| ☐ Office visit notes | ☐ Laboratory results | ☐ X-ray and imaging reports |
| ☐ Specialist and consultant letters | ☐ Newborn and hospital records | ☐ School and developmental forms |
| ☐ Problem list and medication list | ☐ Billing records | ☐ Other, described below |

IF OTHER, OR IF YOU ONLY WANT PART OF THE RECORD, DESCRIBE IT HERE

RECORDS FROM THIS DATE

TO THIS DATE

SPECIALLY PROTECTED INFORMATION

tick only what you want released

Michigan and federal law give these categories extra protection. They are released only if you specifically authorize each one here. Leaving them blank does not delay the rest of the record.

- | | | |
|--|---|--|
| ☐ HIV and AIDS testing or treatment | ☐ Sexually transmitted infection | ☐ Substance use treatment |
| ☐ Mental health and counseling | ☐ Genetic testing | ☐ Pregnancy and reproductive care |

For teenagers. Some records related to care a minor may consent to under Michigan law may require the minor's authorization before they can be released.

Authorization to Release Medical Records, continued

WHY

PURPOSE OF THIS RELEASE

- ☐ Transferring care ☐ Second opinion ☐ School or camp ☐ Personal copy
☐ Legal matter ☐ Insurance or disability ☐ Other

IF OTHER, PLEASE DESCRIBE

HOW LONG THIS AUTHORIZATION LASTS

Unless you set a date or an event below, this authorization expires one year from the date you sign it.

EXPIRES ON THIS DATE

OR WHEN THIS HAPPENS

YOUR RIGHTS

- You may revoke this authorization at any time by writing to the practice. Revoking it does not undo anything already released in reliance on it.
- Treatment, payment, enrollment and eligibility for benefits cannot be conditioned on whether you sign this, except where the law allows it.
- Once information is released to someone who is not a health care provider or health plan, federal privacy law may no longer protect it and it could be passed on again.
- You are entitled to a copy of this signed authorization.

Belleville Lake Pediatrics does not charge a fee for records sent directly to another physician for your child's care.

SIGNATURE

I AM SIGNING AS

- ☐ Parent or legal guardian ☐ Patient, age 18 or older
☐ Adolescent patient, for their own confidential records ☐ Personal representative, documentation attached

PARENT OR LEGAL GUARDIAN, PRINTED NAME

RELATIONSHIP TO PATIENT

DATE

Signature

sign here if you are printing this form

OFFICE USE ONLY

Received

Sent or requested

Method

Pages

Staff initials