NORTHPOINTE Pediatrics

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Please circle appropriate choice below:

I authorize: Northpointe Pediatrics, PC
30061 Schoenherr Suite A
Warren, MI 48088
Phone#586-558-2111
Fax#586-558-3665

Release Medical Records TO or FROM (circle one)
_____ (Name/Facility/Provider)
_____(Address)
_____
_____ (Phone#)
_____ (Fax #)

To release certain protected health information (PHI) about my child/ren listed below including any which may relate to:

The information to be disclosed from medical record:

- **Specific dates of service (please list dates)** _____
- **Entire medical/vaccine record** _____
- **Last checkup/vaccine record** _____
- **Other (please state reason)** _____

Purpose of this request: _____ Personal _____ Legal _____ Insurance _____ Transfer of Care

This information is being released for the specific purpose above. I further understand that records from other healthcare providers will not be released with this request, nor will this information or record be made available to any other person or agency unless another authorization is obtained. This consent can be revoked in writing, except in those circumstances in which the information has already been released. I understand signing this form I voluntary and I do no need to sign this form to assure treatment. When this information is used or disclosed as requested by this authorization, it may be subject to disclosure by the recipient and may no longer be protected by federal HIPAA Privacy Rule. This authorization will expire in 3 months from date of my signature or upon completion of forwarding records to named party.

_____ _____

Patients Name Patients Date of Birth

_____ _____ _____

Print Patient/Parent/Guardian Name Patient/Parent/Guardian Signature Date