

REQUEST FOR RELEASE OF MEDICAL INFORMATION

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

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 (list specific dates or event): _____

*entire medical/vaccine record: _____

*last checkup/vaccine record: _____

*other (please state reason): _____

Purpose of this request: _____

This information is being released for the specific purpose stated 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 had already been released. I understand signing this form is voluntary and I do not 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 3 months from date of my signature or upon completion of forwarding records to named party.

Child/ren:

_____	_____
Name	Date of Birth

_____	_____
Name	Date of Birth

_____	_____
Name	Date of Birth

Forward records to: _____ (Healthcare provider)

_____ (Address)

_____ (Phone number)

_____ (Fax number)

_____	_____	_____
Print Patient/Parent/Guardian Name	Patient/Parent/Guardian signature	Date