CHILD HEALTH PARTNERS, P.C.
1515 Lake Lansing Road C-2
Lansing, Michigan 48912
(517) 482-9582 Fax (517) 482-4304

Authorization for Release or Exchange Medical Records

PATIENT NAME:_____ **BIRTHDATE:**_____

PATIENT NAME: _____ **BIRTHDATE:**_____

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION

From: _____
(Person/entity authorized to **disclose** this information)
_____
Address
_____
_____
Phone/Fax Number

To: _____
(Person/entity to **receive** this information)
_____
Address
_____
_____
Phone/Fax Number

SECTION A:

Please check the type of release you are requesting:

____ Transfer to another practice (This transfer includes all information from the patient's chart for the last 2 years other than information listed in Section B. Please fill out Section B if you require those articles to be sent.)
____ For personal review (Please specify visit date(s) needed): _____
____ Immunization records only
____ Laboratory/Pathology/X-Ray reports only
____ Consultation/Referral purposes (Please specify visit date(s) needed): _____
____ Insurance Co./Attorney (Please specify visit date(s) needed): _____
____ Other (please specify) _____
____ Release to share information (This release includes all information from the patient's chart other than the information listed in Section B. Please fill out Section B if you require those articles to be released.)

SECTION B:

The following information will **NOT** be released unless the appropriate slot is **initialed:**

____ Information related to testing or treatment of sexually transmitted diseases, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and AIDS Related Complex (ARC).
____ Any and all alcohol and drug abuse treatment information.
____ Mental Health treatment records, psychological services and social services information, including communications made by me to social worker or psychologist. (unless records are labeled not to reproduce.)

Release and/or Exchange of information, may be written records, shared by fax, telephone, or in person. I may revoke this release at any time by providing notice in writing to Child Health Partners, P.C.

_____ _____ _____
Signature Relationship to Patient Date
(If patient is 18 years old, they must sign for themselves.)