



4520 Beckley Rd., Battle Creek, MI 49015 Ph: (269) 969-8723 Fax: (269) 969-8724 www.cerealcitypeds.com

Medical Records Release
Attention!!!

PLEASE DO NOT FAX MORE THAN 20 PAGES OF RECORDS.
Please send 20+ pages via mail or on disk.

I hereby authorize:

 Name of Facility/Provider/Organization

 Address

 City State Zip

 Phone # Fax#

To release information to:

 Name of Facility/Provider/Organization

 Address

 City State Zip

 Phone # Fax#

Specific dates and /or type of information to be disclosed:

_____ Progress Notes _____ Radiological Reports _____ Immunization Record
 _____ Lab Results _____ Other (Specify) _____

If you do not wish for the following information to be released, please do not initial.

My initial below specifically indicates by authorization for the release of the release of the following information:

_____ Drug and/or alcohol abuse and/or treatment
 _____ Mental health diagnosis and/or treatment
 _____ HIV/AIDS testing, diagnosis and/or treatment

This information is for the following purpose:

_____ Change of Physician
 _____ Moved out of area – Where to: _____
 _____ Other (Explain) _____

I understand that this release is effective for ninety (90) days from the date of execution and will only authorize release of records prior to date of signature. (Please keep in mind that any document not part of the chart at time of signature will not be released.) However, it may be revoked by me at any time by providing written notice to the above party.

If deemed necessary by Doctor/Facility, I authorize this information to be sent via a facsimile (fax) transmission.

The Physician, Facility and their employee's are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand there is a possibility the information may be re-disclosed by the recipient and no longer protected under the federal privacy rules. I understand this is an optional form and my refusal to sign will not affect my ability to obtain treatment and I may obtain a photocopy of this form on request.

 Patient's Name (Please Print) Date of Birth

 Parent/Legal Representative Signature Relationship to Patient Date

 Witness