Cereal City Pediatrics
there as they grow
4520 Beckley Rd., Battle Creek, MI 49015 Ph: (269) 969-8723 Fax: (269) 969-8724 www.cerealcitypeds.com

Medical Records Release

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
_____ Lab Results
_____ Radiological Reports
_____ 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