HOLLAND PEDIATRIC ASSOCIATES, PLC

926 Washington Ave., Building C • Holland, MI 49423 • www.hollandpediatrics.com • P: 616.393.0166 • F: 616.393.0167

CONSENT TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Primary Care Physician: ☐ Kathryn M. Davis, MD, FAAP ☐ Daniela J. Egelmeer, DO, FAAP ☐ Eric R. Green, MD, FAAP
☐ Lauren A. Mortensen, MD, FAAP ☐ Jeanne R. Poel, MD, FAAP ☐ R. Garett Shook, DO, FACOP

PLEASE NOTE: The name, phone number and fax number of the person/facility the records are being released from are required. These required items are STARRED below. (Please provide the address if available.)

Release FROM:
*Name of Office: _____
*Name of Doctor: _____
*Phone Number: _____
*Fax Number: _____
Address: _____
_____

Release TO: Holland Pediatric Associates, PLC
926 Washington Avenue
Building C
Holland, MI 49423
P: 616.393.0166
F: 616.393.0167

Medical Information to be Released:

☐ Entire Medical Record, *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ Entire Medical Record, *EXCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ Record(s) of care from _____ to _____ *INCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ Record(s) of care from _____ to _____ *EXCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ If deemed necessary by Doctor _____, I authorize this information to be sent via fax transmission.

☐ Other: _____
_____

IMPORTANT NOTE FOR PATIENTS 18 YEARS OF AGE OR OLDER

If releasing records for a patient **18 years of age or older**, the **PATIENT'S** signature is required.
*Parents/legal guardians (of patient's 18+ years of age) cannot sign without a court document stating they have legal guardianship of the patient. Guardianship papers must be provided.

I authorize medical information to be released as indicated above. I understand this release is effective for six months from the date of execution, but that I may revoke my consent at any time by providing written consent to the above named party.

_____ _____
SIGNATURE of Biological/Adoptive Parent or Legal Guardian (If patient is 18+ years of age, the PATIENT needs to sign.) | Today's Date (We require 5-7 business days to process.)

_____ _____
PRINTED NAME of Person Signing | Relationship to Patient

_____
Phone Number

_____ _____
Signature of Witness | Date Signature Witnessed