

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

Authorization for Release or Exchange Medical Records

PATIENT NAME: _____ BIRTHDATE: _____

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I authorize Child Health Partners, P.C. to release medical information to:

Name: _____ Title: _____

(Provider/parent/teacher/other)

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

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.)

Please allow 28 days from date request was received. There is a charge for record transfers.