Forest Hills Pediatric Associates

Consent to Release Medical Information

Patient Name:_________________________________ Date of Birth: ______________

William Bush, MD	Marcy Larson, MD	Claire Olgren, MD
Joan Downs, MD	Brian LeCleir, MD	Barbara Periard, MD
Cheryl Dyksen, MD	Randy Leja, DO	Richard Wood, MD
Kathleen Howard, MD	Michael Meindertsma, MD	Cara Zokoe, MD

Medical Information to be sent:

________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 for 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 for HIV/AIDS

_______Record of Care from ______to______ **INCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment for HIV/AIDS.

_______Record of Care from ______to______ **EXCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment for HIV/AIDS.

_______If deemed necessary by Dr. _______________, I authorize this necessary information to be sent via fax transmission.

I authorize medical information to be released as indicated above. I understand this release is effective for 6 months from the date of execution, but I may revoke my consent at any time by providing written consent to the above named party.

____
Legal Guardian or Adult Patient (Print)

____
Phone Number

____
Witness

____
Signature (Legal Guardian or Adult Patient)

____
Date

Release From: _________________________
____
____

Release To: Forest Hills Pediatrics
877 Forest Hill Ave SE
Grand Rapids, MI 49546
Fax: 616-949-6191
Phone: 616-949-4465