Authorization to Release Medical Information

Who is sending the records?

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Who is receiving the records?

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

I authorize Fox Pediatrics to use or disclose my identifiable health information as described below. I understand the information may be subjected to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that this information may be sent via fax, email or electronic transmission. This authorization will expire six (6) months from the date of signature, but I may revoke my consent at any time by written notice.

Medical Information to be sent:

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

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

_____ Specific Medical Information to be used or disclosed. Please describe documentation requested in detail (on back)

Patient Name: _____Date of Birth: _____

Current Address:_____

Phone: _____

Signature of Parent or Guardian: _____

Printed Name of Parent or Guardian: _____ Date:_____

Fox Pediatrics

Constanza I. Fox, M.D.
1205 S Mission St #4
Mount Pleasant, MI 48858
(989) 400-4369
Fax #: (989) 400-4376