

**Trestlewood Pediatrics**  
**Authorization for Release of Medical Information**

I, \_\_\_\_\_ authorize Trestlewood Pediatrics to release the following medical

Information to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

Any and all of my medical records (as of the date of this release)

Immunizations Only

Any and all of my medical records **except** the following \_\_\_\_\_

**Please initial below if you want the following to be released.** This information **will not** be released unless the appropriate line is initialed

Any record of treatment and /or alcohol dependency or abuse.

Any record of mental health treatment

Any record of testing, care treatment, reporting or research pertaining to infection with HIV or other immune disorders.

**This information is being released for the following purpose(s).**

Relocating and transferring outside the Kalamazoo area.

Transferring to an adult doctor in the area (patient has outgrown pediatric age).

Seeing a Specialist.

Insurance company request.

Transferring to a new pediatrician due to dissatisfaction related to one or more of the following:

Convenience of the office location

Waiting time in office

Pediatrician's care of child

Nursing staff

Interactions with other staff

Difficulty scheduling timely appointments

Changes of insurance. If so, Please list new insurance \_\_\_\_\_

Other (Please comment below) \_\_\_\_\_

Other \_\_\_\_\_

**I understand that I will be responsible for the fees associated with the medical records request as per laws of the State of Michigan.** This release is effective for six months from the date of execution. However, it may be revoked by me at any time by providing notice in writing to the above named party, but that the revocation will not apply to information already released based on the authorization. I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules. I understand that authorizing the disclosure of the health information is voluntary.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Office use only    \_\_\_/\_\_\_/\_\_\_    Date information released    Initials \_\_\_\_\_