This form can be signed electronically by selecting the "I Accept" box below and typing your name on the signature line or you can print and sign the form manually. The form can be returned to us securely by saving the form and reply to the email attaching the saved form, or it can be mailed, faxed, sent through patient portal or brought to the office.

Clear Form Save & Print

PORT CITY PEDIATRICS

PORT CITY PEDIATRICS
1455 Farr Road Norton Shores, MI 49444

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____/_____/_____

Phone: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Authorization By: _____ ☐ **Patient** ☐ **Parent** ☐ **Legal Guardian**

ATTENTION: There will be a fee assessed to copy records. If you are transferring to another office or if records are requested by another physician, there may be no charge. Once the patient has transferred and records have been released, there will be a charge for any additional records request. Of note: Records may be sent in digital format.

I understand that I am hereby expressly directing you, the custodian of medical records referred to below, to release medical information or personal health information (PHI) that concerns minors and may be related to HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome), STD's (sexually transmitted diseases), mental health or substance abuse screening and counseling, unless I specifically ask for an exclusion of that information.

RECORD RELEASE

☐ I authorize my records to be **SENT TO** the below physician:

☐ Richard Golz, M.D.
☐ Alison Fox, M.D.
☐ Elizabeth Pallante, M.D.
☐ Paul Alban, M.D.
☐ Karl Nicles, M.D.
☐ Dustin Miller, M.D.
☐ Jessica Pedersen, M.D.

☐ I authorize my records to be **RELEASED FROM:**

ATTENTION!
IF FAXING MORE THAN 20 PAGES OF RECORDS, PLEASE FAX TO 231-739-8502 OR, SEND BY MAIL, ON A DISK OR FLASH DRIVE.

Name of person/organization: _____

Address: _____

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

REASONS FOR RELEASE: ☐ Transfer ☐ Referral/Consult ☐ Attorney ☐ Other _____

Information to be released: ☐ Entire Record ***THIS INCLUDES GROWTH CHART AND COMPLETE SHOT RECORD*** (all dates of service)

☐ **Exceptions** of the medical record that you want specifically excluded _____

☐ If not entire record, ***circle what is to be sent***: ☐ Consults ☐ History & Physical ☐ Office Notes ☐ Hospital Notes ☐ EEG/EKG ☐ Radiology Reports ☐ ER Records ☐ Surgical Reports ☐ Labs ☐ Discharge Summary

For items circled above, **what dates of service?** From _____ To _____

I understand that this authorization will automatically expire once the purpose of which it was signed has been accomplished. I also understand that I may revoke this authorization in writing at any time, unless the request has already been acted upon. Unless otherwise revoked, this consent expires one year from the date of signature below.

☐ **I Accept. By selecting the "I Accept" button and typing your name below, you are signing this Agreement electronically.**

_____ Date: _____

Signature of Patient if 18 years/Parent/Legal Guardian