4986 N Adams Rd, Suite B
Oakland Township, MI 48306
Tel: (248)-609-1800
Fax: (248)-278-4977

Authorization for Release of Medical Information

Patient Name: ____ DOB: ____/____/_______

I, ____ hereby authorize the release of medical
(patient's name)
information **TO:**

Monarch Pediatrics
4986 N Adams Rd Suite B Oakland Township MI 48306
Tel: (248)-609-1800 Fax: (248)-278-4977

FROM:
Doctor/Clinic/Hospital:____

Address: ____

____

Telephone: _______________________________ Fax : _________________________

Please release the following:
___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam ___ Discharge Summary ___ Diagnostic Test Reports ___ Lab Results
___ Progress Notes ___ Consultation Reports ___ Radiology/Images ___ Pathology Reports
___Other (specify): ________________________

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure:
___ Treatment/ Continuing medical care

Rev 10/20/21

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I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective as valid as the original.

Signature of Parent or Legal Guardian: ___________________________________ Date: ____/____/____

Print Name: ___________________________________ Relationship to Patient: ___________________