



HOLLAND PEDIATRIC ASSOCIATES, PLC

926 Washington Ave., Building C • Holland, MI 49423 • www.hollandpediatrics.com • P: 616.393.0166 • F: 616.393.0167

CONSENT TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Primary Care Physician: Kathryn M. Davis, MD, FAAP Daniela J. Egelmeer, DO, FAAP Eric R. Green, MD, FAAP
 Lauren A. Mortensen, MD, FAAP Jeanne R. Poel, MD, FAAP R. Garrett Shook, DO, FACOP

PLEASE NOTE: The name, phone number and fax number of the person/facility the records are being released from are required. These required items are STARRED below. (Please provide the address if available.)

Release FROM: * Name of Office: _____
* Name of Doctor: _____
* Phone Number: _____
* Fax Number: _____
Address: _____

Release TO: Holland Pediatric Associates, PLC
926 Washington Avenue
Building C
Holland, MI 49423
P: 616.393.0166
F: 616.393.0167

Please Note: We do not accept records on CDs.
We apologize for any inconvenience this may cause.

Medical Information to be Released (please choose one):

- Entire Medical Record, *INCLUDING* the vaccine record and information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of 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 of HIV/AIDS.
- Record(s) of care from _____ to _____ *INCLUDING* the vaccine record and information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.
- Record(s) of care from _____ to _____ *EXCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.
- If deemed necessary by Doctor _____, I authorize this information to be sent via fax transmission.
- Other: _____

Reason(s) for Releasing Records: Age Moving Changing Doctors Dissatisfied
 Other: _____

IMPORTANT NOTE FOR PATIENTS 18 YEARS OF AGE OR OLDER

If releasing records for a patient **18 years of age or older**, the **PATIENT'S** signature is required.
*Parents/legal guardians (of patient's 18+ years of age) cannot sign without a court document stating they have legal guardianship of the patient. Guardianship papers must be provided.

I authorize medical information to be released as indicated above. I understand this release is effective for 60 days from the date of execution, but that I may revoke my consent at any time by providing written consent to the above named party.

SIGNATURE of Biological/Adoptive Parent or Legal Guardian
(If patient is 18+ years of age, the PATIENT needs to sign.)

Today's Date
(We require 5-7 business days to process.)

PRINTED NAME of Person Signing

Relationship to Patient

Phone Number

Signature of Witness

Date Signature Witnessed