Forest Hills Pediatric Associates

Consent to Release Medical Information

Patient Name: _____ Date of Birth: _____

Natalie Brenders, MD	William Bush, MD	Tina Daniels, MD
Cheryl Dyksen, MD	Alissa Enzenberger, MD	Kathleen Howard, MD
Marcy Larson, MD	Brian LeCleir, MD	Randall Leja, DO
Michael Meindertsma, MD	Megan Petty, MD	Austin Voydanoff, MD
Cara Zokoe, MD		

Medical Information to be sent:

_____Entire Medical Record, **INCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment for 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 for HIV/AIDS

_____Record of Care from _____to_____**INCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment for HIV/AIDS.

_____Record of Care from _____to_____**EXCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment for HIV/AIDS.

_____If deemed necessary by Dr. _____, I authorize this necessary information to be sent via fax transmission.

I authorize medical information to be released as indicated above. I understand this release is effective for 6 months from the date of execution, but I may revoke my consent at any time by providing written consent to the above-named party.

_____
Legal Guardian/Adult (**18 and over**) Patient (Print)

_____
Phone Number

_____
Witness

_____
Signature (Legal Guardian or Adult Patient)

_____
Date

Release From: _____

_____

_____

Release To: Forest Hills Pediatrics
877 Forest Hill Ave SE
Grand Rapids, MI 49546
Fax: 616-949-6191
Phone: 616-949-4465