Brookville
PEDIATRIC + INTERNAL MEDICINE

Authorization to Release Medical Records TO Brookville

Patient's Name: _____ Date of Birth: ____/_____/____ Date of Request:

Address: _____ _____ Day Time Phone: (____) ___
(Street, city, state, zip code)

Please list the entity from where the medical information is requested:

Facility/Office: _____ Fax Number: _____

Address: _____ Phone Number: _____

City/State/Zip:_____ _____ _____

Dates of Service: _____**Reason for request:**_____

Please send requested information TO **Brookville Pediatric and Internal Medicine**

1200 56th Street SW, Wyoming, MI 49509 (Wyoming and Rockford Patients)
Fax Number: (616) 514-3802

The following information is to be disclosed TO Brookville Pediatric & Internal Medicine at patient request: (ONLY the information selected below will be sent.)

List of records to be sent: (check only those items of the record to be disclosed)

☐ Problem List ☐ Immunization Record ☐ Medication List ☐ Last Well Visit
☐ Growth Chart ☐ Drug Allergy History ☐ ADHD History (if applicable)
☐ Complete Record

- **Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
- **Re-disclosure:** I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
- **Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand that the revocation will not apply to information already released based on this authorization.
- **Other Rights:** a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. b) I understand that I may inspect or obtain a copy of this information to be used or disclosed.
- **Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event or condition: If I do not specify an expiration date, event or condition, this authorization will expire six months from the date signed. Earlier expiration date:_____

By signing this form, I understand and accept full responsibility for the medical records I am requesting.

_____

Signature of patient or legal representative Date

_____

Legal representative printed name and relationship to patient