Southfield Pediatric Physicians

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39525 14 Mile Road, Ste 200A
Novi, MI 48377
(248) 960-7091
Fax: (248) 960-7392

Authorization to Release Records

_____ _____
Patient DOB Patient DOB

_____ _____
Patient DOB Patient DOB

I,_____, as parent, guardian authorize Southfield Pediatrics to
parent/guardian

release medical records to:

Dr.:_____

Address:_____

Phone:_____ Fax:_____

Reason for Request:

☐ moving out of area ☐ dissatisfied with practice ☐ change of insurance

☐ continued care with specialist ☐ other_____

I authorize release of the entire medical record including drug, chemical dependency, alcohol abuse, mental health, communicable disease including sexually transmitted disease and any and all other records in accordance with Federal Regulations.
I expressly authorize information concerning the following serious communicable diseases to be released:

HIV
AIDS-Related Complex (ARC)
Acquired Immunodeficiency Syndrome (AIDS)

_____ _____
Parent/Guardian/Patient Signature Date

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation(42 CFR Part 2 and Public Act 258) prohibit from making further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. This authorization is valid for one year from the date of request unless otherwise revoked in writing to Southfield Pediatric Physicians.