Mackinaw Trail Pediatrics

Specialists in Children's Healthcare

Records Release Form

I, _____authorize: Name/Facility: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

to release to Mackinaw Trail Pediatrics the information in the medical record of:

Patient Name: _____Birth Date: _____

Please check the appropriate line:

_____Any and all medical records up to and including the date of this release.

_____Any and all medical records EXCEPT: _____

_____Records pertaining to: _____

Purpose of release:

_____Medical Care _____Personal Information _____ School/Daycare

_____Insurance _____Other: _____

This release will be effective for one year from the date of execution unless revoked in writing from me to the above-named facility.

Parent/Representative: _____Date: _____

Relationship to patient (if applicable): _____

Parent/Representative Phone Number (optional): _____

Upon written signature of this document, I have consented if deemed necessary by Doctor/Facility to have information sent via facsimile transmission. Any information related to HIV infection or AIDS cannot be released with this document. If any information regarding this issue is desired, a separate release must be obtained.

The recipient of the enclosed information is not authorized to use this patient's medical records for any purpose other than for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from the patient to do so.

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