New Horizons Pediatrics

New Horizons Pediatrics
3945 Okemos Rd, Ste A1
Okemos, MI 48864
Phone: 517-295 5000
Fax: 517-507 5424

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ DOB: _____
Patient Name

_____ SS# _____
Patient Address

authorize _____
Name of Physician, Practice, Facility, etc.

_____
Name of Physician, Practice, Facility, etc

to provide __Pratima Boinepalli, MD, New Horizons Pediatrics, 3945 Okemos, Rd, Okemos, MI, 48864, _Tel:517-295 5000, Fax: 517-507 5424_____

The information to be released is (state specific documents, time period, etc.):

_____

Purpose or need for the information requested:

Continued Care _____ Insurance _____ Legal _____ Transfer _____ Personal _____

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____ _____
Patient/Parent/Legal Guardian Signature Relationship Date

_____ _____
Witness Signature Date

If signed by other than patient, state relationship and reason for patient's inability to sign.

_____

Office Use Only: