MOORE PEDIATRICS & ASSOCIATES
13699 Old US 12
Chelsea MI 48118
734.475.4500-telephone
734.475.4507-fax

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I, ________________________________, HEREBY GIVE MY CONSENT TO MOORE PEDIATRICS & ASSOCIATES TO RELEASE RECORDS TO OR OBTAIN THEM FROM:

Name: ____________________________________ Address: ___________________________

City: ______________________________ State: _______________ Zip: __________________

2. INFORMATION FROM THE MEDICAL RECORD OF:

Patient Name: ____ D.O.B_________________

Patient Name: ____ D.O.B_________________

Patient Name: ____ D.O.B_________________

3. INFORMATION TO BE RELEASED:
   ____All Records_____Progress Notes _____Lab Reports
   _____X-ray Reports _____Other:________________________

4. I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION REGARDING:
   _____Substance abuse _____Mental Health
   _____HIV related information (AIDS related testing)

   X____ **DATE**_________________
   (SIGNATURE OF PATIENT OR LEGAL GUARDIAN)

5. PURPOSE OF RELEASE: _____Medical Care _____Insurance _____ Relocating

6. This authorization shall be effective following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the above listed Physician or Facility. A photocopy of this authorization shall constitute a valid authorization.

7. The Physician, Facility, and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

   X________________________________ **DATE**________________________
   (SIGNATURE OF PATIENT OR LEGAL GUARDIAN)

NOTICE TO RECIPIENT

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.