St. Clair Pediatrics, LLC
Authorization for Release of Health Information

Patient Name: _____
Last First MI

Date of Birth: _____
MM/DD/YYYY

I authorize and request: _____
Name of Physician or Medical Facility

_____
Street Address

_____
City State Zip

To release to: _____
Name of Physician or Medical Facility

_____
Street Address

_____
City State Zip

Medical Records covering the periods from: _____ to _____
MM/DD/YYYY MM/DD/YYYY

Requested medical information is needed for: _____

Reason for transfer: Moving Away Non-participation with Insurance Transitioning to Family Practice/Internal Medicine

Issues with our practice Would you like for our Office Manager to contact you? Y N

I understand that my medical records or the medical record of the patient for whom I am signing may include Alcohol/Drug abuse, Psychiatric treatment or HIV/AIDS testing or treatment and are covered by Federal Regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event, this consent will expire ninety (90) days from the date the authorization is signed. St Clair Pediatrics, LLC, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

_____ _____ _____
Patient Signature or Legal Representative Relationship to Patient Date

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