

LAKESHORE INTERNAL MEDICINE AND PEDIATRIC ASSOCIATES
Greg Schrottenboer, MD Tricia Miller, MD Brian Drozdowski, MD Scott Parrott, PA-C
 437 N. 120th Ave. Holland, MI 49424 (616)738-0737
MEDICAL RECORDS - AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____ Phone #: _____

I hereby authorize any and all treating physicians, institutions, nurses, psychologists, therapists, social workers, etc, to release information in my chart, as well as verbal information, to the individual or organization listed below.

****NOTE: We cannot request/send the records without a phone, fax, and/or address of facility.****

1. Records to be sent TO: Name: Lakeshore Internal Medicine and Pediatrics Address: 437 N 120 th Ave City/State/Zip: Holland, MI 49424 Phone # for above: 616-738-0737 Fax # for above: 616-738-0575	Records to be released FROM: Name: _____ Address: _____ City/State/Zip: _____ Phone # for above: _____ Fax # for above: _____
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2. Information to be sent:

- Entire Record
- Specific **Pediatric** Information (age 11 and up): Out of state immunizations - Growth Charts – Surgeries – Medical Summary – Problem list – Medication list – Surgical history – Family history – Labs (last 3 years) – Last 5 office visits
- Specific **Adult** Information: Medical summary - Problem list - Medication list - Last mammogram - Last colonoscopy - Last pap smear – Surgical history – Family history – Labs (last 3 years) – EKG's – Last 5 office visits
- Other: _____

3. Purpose for this disclosure:

- Changing physicians
Reason for changing: _____
- Other: _____

Specific type of information which may be disclosed: Any and all records that are requested above concerning your treatment, care, evaluation, counseling, therapy and or medical provider service of any kind rendered including evaluation, and/or treatment, recorded notes of any kind, computer entered notes, all forms including work generated such as FMLA and disability, and any other written information of any kind contained within the medical file pertaining to this patient. Please be advised that any correspondence from specialist will not be included and will need to be obtained from that facility.

I UNDERSTAND that my records are protected under Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I FURTHER UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE INCLUDE: DIAGNOSIS, PROGNOSIS AND TREATMENT FOR PHYSICAL AND/OR EMOTIONAL ILLNESS, INCLUDING TREATMENT OF ALCOHOL OR CHEMICAL DEPENDENCY; ALSO DIAGNOSIS, TESTING FOR AN/OR TREATMENT WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HIV INFECTION, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR ACQUIRED IMMUNODEFICIENCY SYNDROME RELATED COMPLEX (ARC).

I UNDERSTAND that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance upon my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to the facility releasing this information. If not revoked, this authorization is valid no longer than that reasonably necessary to effectuate the purpose for which it is given or until it expires 1 year from the date signed below or the conclusion of the litigation currently pending. I understand my signature below indicates I have read all information. I HEREBY RELEASE any and all providers, Their employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of the information set forth above relating to my file.

Signature: _____ Date: _____ Relationship: _____

Witness: _____ Date: _____