ALGER PEDIATRICS, P.C.

733 Alger SE Grand Rapids, MI 49507 | Phone: 616-243-9515 | Fax: 616-243-1815

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

Patient Name Date of Birth

_____

Patient Name Date of Birth

_____

Patient Name Date of Birth

_____

Patient Name Date of Birth

☐ Transferring to a different office ☐ Personal copy of records

Protected health information to be disclosed:

____ Entire medical record ($20 fee)

_____ Last well visit, immunization record, and problem list **only**. These 3 pages provided at no charge.

*Please note that if records are requested for more than one family member, the initial record fee is $20, plus an additional $5 for each family member. **Payment must be provided prior to records being sent.**

I request and authorize the disclosure or release of my records (protected health information) to the following:

Name: _____

Address: _____

City, State, Zip: _____

Fax Number: _____

_____

Printed name Signature Date