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

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Patient Name   Date of Birth

Protected health information to be disclosed:

_____ Entire medical record $20 Fee

*Please note if records are requested for more than 1 family member the initial record fee is $20 and it is an additional $5 for each family member. Please list name and date of birth of other family members you are requesting their entire medical record for.

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_____ Last Well Child Exam, Immunization Record and Problem list. These 3 pages provided at no charge

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

Name:____

Address:____

City, State, Zip____

Fax Number:____

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Signature   **Printed Name**   **Date**