MEDICAL CENTER PEDIATRICS P.L.L.C
MEDICAL RELEASE AUTHORIZATION (Out)

I authorize the release of medical records to:

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax:_____

Regarding the following patient(s):

Patient Name: _____DOB:_____

Patient Name: _____DOB:_____

Patient Name: _____DOB:_____

Patient Name: _____DOB:_____

Options:
_____Immunization Only

_____Entire Chart (paper charts copied through HealthPort)

_____Other (Please be specific)_____

Parent/Guardian:

Sign:_____Date:_____

Print Name:_____Date of Birth:_____

Relationship to patient:_____

Address: _____

City: _____State:_____Zip:_____

Primary Phone Number:_____Alternate Phone:_____

Medical Center Pediatrics
30400Telegraph Rd Ste 101
Bingham Farms, MI 48025
Phone: (248) 642-5437
Fax: (248) 642-5456

Medical Center Pediatrics
5793 West Maple Rd. Ste 153
West Bloomfield, MI 48322
Phone: (248) 539-7726
Fax: (248) 539-7823

Release of Information Division

Medical Center Pediatrics has contracted with HealthPort to process your request for medical records. The following rates are applicable:

PATIENT REQUESTS

There will be a charge to patients who request copies of their medical records for their own use or who transfer to another provider. The charge for this service will be:

$1.17 per page 1-20
$0.59 per page 21-50
$0.23 per page 51+

Plus tax and postage for these requests. Patients will receive an invoice from HealthPort.

These charges are regulated by the State of Michigan.

Direct questions call (800)367-1500 for Customer Service

By signing this form I acknowledge that I will be responsible for any charges for reproduction of my medical records and will receive a statement directly from HealthPort.

Patient Name:_____

Date of Birth_____

Signature_____

Today's Date _____