Internal Medicine and Pediatrics
of West Michigan
Michael J. App MD FAAP, PLC
Allison Boonie, NPC
Kelly Burri, NPC
Tena Landers, NPC

Request for Release of Medical Records

To: _____

Address: _____

_____

Phone: _____ Fax: _____

I hereby authorize you to release medical records of:

Patient Name: _____
Date of Birth: _____

Please send records to:
Internal Medicine and Pediatrics of West Michigan
Dr. Michael App MD, Allison Boonie NP-C, Kelly Burri NP-C and Tena Landers NP-C
1959 East Paris Ave SE
Grand Rapids, MI 49546
Phone: (616)-363-7690
Fax: (616)-363-7680

Information needed:

____All Records ____Hospital Stay _____ Immunizations _____Laboratory

____Operative Report _____Imaging _____Other

Patient Signature: _____ Date: _____

I understand that the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal and state laws protecting its confidentiality, I understand that I may revoke this release in writing at any time to Internal Medicine and Pediatrics of West Michigan, but that my revocation will not affect disclosures already made by a provider relying on this authorization. I understand that signing this form is voluntary and that my services will not be affected if I choose not to sign the form. This release will expire within 60 days from the date signed.

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or STD/AIDS information _____ initial