



Healthy kids and teens. Bright futures... One child at a time.

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### Release of Information

On this Date: \_\_\_\_\_

I hereby Authorize Midwest Child & Adolescent Specialty Group to:

- Release
- Obtain

**The Following Information:**

- Specific Office Note:** Exam Date \_\_\_\_\_
- Specific Diagnostics:** Test: \_\_\_\_\_ Date of Service: \_\_\_\_\_
- Copy of COMPLETE Health Record:** (includes but not limited to: Demographic/ Insurance information, Exam/Office notes, Appointment history, Inpatient/Outpatient/Emergency Room visits, social worker records, treatment plans, consultations, All diagnostic testing results, all signed orders and correspondence)
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**For Patient:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

**Information Going To / From:**

Person/Office: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax Number: \_\_\_\_\_

**Reason:**

- Transfer of Care (*once transferred, patient may return after 1 year, if not dismissed*)
- Court
- Specialist
- Personal

\*I understand the information to be released/disclosed may include information relating to sexually transmitted disease, AIDS, HPV, and Alcohol/Drug abuse. By my signature, I authorize this disclosure. I also understand and agree to pay any fees for copying records.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

(Parent/Legal Authorized Representative)