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Authorization for the Release of Protected Health Information

I authorize Bay Pediatric Clinic, PC to release health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services) under the following terms and conditions. I understand that Michigan law allows a reasonable fee for the requested copies of medical records.

_____ _____ _____
NAME DATE OF BIRTH ADDRESS

_____ _____ _____
NAME DATE OF BIRTH CITY, STATE, ZIP CODE

_____ _____
NAME DATE OF BIRTH PHONE

Information to be disclosed:

_____ Any and all medical records _____ Note with Diagnosis or Protected health information

_____ Other (please specify): _____

Purpose for Disclosure:

_____ Continuation of medical care _____ Return to Work/School/Sports

_____ Other: _____

Release Information to:

_____
NAME

_____
ADDRESS

_____
CITY, STATE, ZIP CODE

_____
FAX:

_____
PHONE:

Release information from:

_____
NAME

_____
ADDRESS

_____
CITY, STATE, ZIP CODE

_____
FAX:

_____
PHONE:

I [illegible] this is if the authorizat [illegible], the recipient has non duty to protect its' confidentiality. The recipient may re-disclose the information as he/she wishes. I cannot be refused treatment if I choose not to sign this form. I understand that if I am authorizing the release of protected health information not created by Bay Pediatric Clinic, PC, the accuracy and completeness of those records created by other providers cannot be verified.

_____ _____ _____
SIGNATURE RELATIONSHIP TO PATIENT DATE

*THIS RELEASAE WILL EXPIRE 1 YEAR FROM THE DATE SIGNED