ABC Pediatrics, PC

4288 Three Mile Rd NW Walker, MI 49534 / 4174 56th Street SW Wyoming, MI 49418 P: (616) 458-3677 F: (616) 459-6850

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth _____

I, the undersigned authorize you to furnish a copy of the following medical records to _____

- □ Laboratory Data
- □ Radiology Reports
- □ Progress/Doctor's Notes
- □ Operative Reports, Findings and Complications
- □ Other Documents (please specify) _____
  _____
- □ Hospital Notes
- □ ER Notes
- □ Pathology Reports

Physician/Practice releasing records:
Name: _____
Address: _____
City/State/Zip: _____
Phone: (____) _____
Fax: (____) _____

Physician/Practice to receive records:
Name: _____
Address: _____
City/State/Zip: _____
Phone: (____) _____
Fax: (____) _____

I authorize the release of these medical records *to* ABC Pediatrics from all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment.

I authorize ABC Pediatrics to release my medical records regarding their treatment to relevant healthcare providers, facilities and diagnostic centers involved in the course of my treatment.

I specifically consent to the disclosure of records to ABC Pediatrics that may contain alcohol/drug/substance abuse information. I specifically consent to the disclosure of these records by ABC Pediatrics to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____ (initials)

I specifically consent to the disclosure of records to ABC Pediatrics that may contain HIV test results or diagnosis of AIDs and AIDs related conditions. I specifically consent to the disclosure of these records by ABC Pediatrics to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____ (initials)

I specifically consent to the disclosure of records to ABC Pediatrics that contain mental health information. I specifically consent to the disclosure of these records by ABC Pediatrics to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____ (initials)

If not previously revoked, this authorization to use or disclose protected health information will expire TWELVE (12) months from the date of my signature or as otherwise specified by date, event or conditions(s) as Follows: _____
_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: ABC Pediatrics Attn: Privacy Contact 4288 Three Mile Road NW Walker, MI 49534. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. [If applicable because the authorization is obtained for marketing purposes.]

_____ _____
Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____
Date | Description of Personal Representative's Authority