Shoreline Pediatrics, P.C.

Patient Authorization to Release Protected Health Information to a Third Party

Patient ______________________________ Birth Date ______________

Address ______________________________ Phone ______________

Information to be Released

_____ Entire Medical Record _____ History & Physical _____ Radiology Reports

_____ Progress/Office Notes _____ Lab/PathReports _____ Billing Information

_____ Immunizations _____ Consults/Letters _____ Discharge Summaries

_____ Other (specify) ______________________________

Dates of Service to be Released

From ______________ To ______________

I would like copies of my health information indicated above sent:

To: ______________________________ From: ______________________________

I authorize the release of health information contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statue and Michigan Department of Public Health rules, which include venereal diseases, Tuberculosis, Hepatitis A, B, C, Human Immunodifficiency Virus (HIV), HIV testing;
- Acquired Immunodifficiency Syndrome (AIDS), and AIDS related complex (ARC);
- Alcohol and drug abuse treatment information protected under the regulations in CFR, Part 2;
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

Purpose of Disclosure:

_____ Continued Care _____ Attorney/Legal _____ Insurance

_____ Personal Use _____ Other (specify) ______________________________

Expiration Date: ______________________

If no express expiration date or revocation is issued, this authorization will expire in **60 days** from the date signed.

When the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Shoreline Pediatrics, P.C. has acted in reliance upon this authorization. My written revocation must be submitted to Shoreline Pediatrics, P.C. at 684 Harvey Street, Suite 201, Muskegon, MI 49442.

______________________________ ______________________________

Signature of Patient, Parent or Legal Guardian Relationship if other than patient

______________________________ ______________ **ID Checked** ______________

Print Name Of person whose signature appears above Date

PATIENT/PARENT/GUARDIAN MUST BE PROVIDED A SIGNED COPY OF THIS AUTHORIZATION.