AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All blanks **MUST** be filled in)

Patient(s):______________________________

____

____

Birthdate______________________________

____

____

Address: ______________________________

____

Telephone: (____)______________

Released From: Premiere Pediatrics
7210 N. Main St., Suite 205
Clarkston, MI 48346

Released To:______________________________

____

____

Type of information to be disclosed:

____ Any and All Records
____ Laboratory Results
____ X-Ray Results
____ Immunization Record

The purpose and need for disclosure:

____Transfer of Care - Reason for Transfer______________________________

____

____ Attorney Request
____ Social Security
____ Insurance
____ Other______________________________
____ Personal Reason______________________________

- Communicable disease and infection information as defined by statute and Michigan Department of Public Health Rules (which include Venereal Disease "VD", Tuberculosis "TB", Hepatitis B, Human Immunodeficiency Virus "HIV", Acquired immunodeficiency Syndrome "AIDS", and AIDS related complex "ARC").
- Alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.
- Mental health treatment records, psychological services and social services information including communications made to me v=by a social worker or a psychologist.

I understand as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at anytime by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

I understands that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.

I understand the Practice 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. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of the same.

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

Without expressed written revocation, this consent expires after one year.

____
Signature of:___**Patient**___**Personal Representative**

____
Printed Name

____
Date

____
Relationship to Patient