PEDIATRIC & ADOLESCENT CENTER

15555 Northline Road
Southgate, MI. 48195
Tel: (734)285-3090
Fax: (734)285-3095

Health Information Release Authorization

Patient full name:_____
Date of birth: _____ Sex:_____ Phone:_____
Address: _____
City: _____ State:_____ Zip:_____

I, _____, hereby authorize _____, its director or agency to release information contained in the medical record of this patient (identified above), which includes information that may be stored in a paper and/or electronic format. This includes information concerning human immunodeficiency (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC), if any, protected under Michigan Public Act: 174 of 2989, as amended and substance abuse information, if any, protected under 42 Code of Federal Regulations, Part 2 and social and psychological services information, if any, including communication made to a social worker or psychologist, if any to the individual(s) or organization(s) and only under the conditions listed below:

1. Name or title of person or organization and address to who is to be:

Disclosed To:	Requested From:
_____	_____
_____	_____
_____	_____
Address	Address

2. The Purpose or need for such disclosure:

☐ Personal Use ☐ Continuation of Care ☐ Attorney ☐ Insurance
☐ Workman's Compensation ☐ Disability ☐ Other:_____

3. Specific information to be disclosed/obtained as related to: (indicate date of service).

☐ ER memo_____ ☐ Outpatient Visit_____
☐ X-ray/ Labs_____ ☐ Discharge Summary _____
☐ Immunizations_____ ☐ Entire Record _____
☐ Other_____

4. This authorization is valid only if received by the Pediatric & Adolescent Center within 90 days of the date signed. I may revoke this authorization anytime. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released persistent to this authorization.

5. Information used/disclosed may be subject to re-disclosure.

6. Pediatric & Adolescent Center and/or its copying services reserve the right to charge for processing and copy information. This fee is waived when releasing information directly to attending physician or health care facility.

Signature:_____ Relationship:_____

Date:_____

Witness Signature: _____ Date:_____