



307 W. Lake Lansing Rd, East Lansing, MI 48823

Phone: 517-487-4480

Fax: 517-487-0193

Authorization for Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

Address: _____

Phone #: _____

1. I authorize disclosure of the protected health information on (date) _____ be made by:

Previous Pediatrician: _____

Address: _____

Information to be disclosed will include, as applicable, unless crossed out:

- Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II
- Information about human immunodeficiency virus-HIV acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC, as defined by Department of Community Health rules (1989 Public Act 174)

2. Person or organization authorized to receive information:

**Pediatric Care of Lansing
307 W. Lake Lansing Rd.
East Lansing, MI 48823**

3. Specific Type of information to be disclosed:

☐ Entire Record ☐ Immunization Record ☐ Records from visit on _____

☐ Other _____

4. This information may be disclosed for the following purpose:

☐ Continued Care ☐ Personal Use ☐ Attorney Use ☐ Insurance use

☐ Other _____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.
6. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be re-disclosed and no longer protected by those laws and regulations.
7. This authorization expires 365 days from date of the signature below unless otherwise requested.

Printed name of patient or patient's representative

Relationship to Child

Signature of patient or patient's representative

Date