

**Downriver Pediatric Associates P.C.**  
23050 West Road Suite 110 Brownstown, MI 48183-1468  
734-671-9800 Fax 734-671-7690

**HEALTH INFORMATION RELEASE AUTHORIZATION**

I. \_\_\_\_\_  
Print Patient's Name Telephone Number

\_\_\_\_\_  
Address

Authorize \_\_\_\_\_  
Name of Facility Releasing Medical Information

\_\_\_\_\_  
Address  
To release information contained in my patient records, including as applicable: information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Consumer and Industry Services (MDCIS) (which include venereal disease "VD", tuberculosis "TB", human immunodeficiency syndrome "AIDS", and AIDS related complex "ARC"), alcohol and drug abuse treatment information protected under the regulation in 42 Code of Federal Regulation, Part 2, psychological services and social services information including communication made by me to a social worker or psychologist, to the individuals or organizations listed below, only under the conditions listed below:

1. Name and address of receiver of information: Downriver Pediatric Associates P.C.  
23050 West Road Suite 110  
Brownstown, MI 48183
2. Specific type of information to be disclosed, (include date(s) of service):  
  
\_\_\_\_\_  
  
\_\_\_\_\_

3. The purpose and need for such disclosure: continuation of care.
4. I understand that I have the right to revoke this authorization at any time except as noted below. I understand that if I revoke this authorization, I must do so in writing and present my written revocations to the appropriate department /facility that was authorized to release information. I understand that the revocation will not apply to information that has already been released in response to this authorizations or where the facility has acted in reliance upon this information. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The right to revoke is also discussed in the facility privacy notice. Unless otherwise revoked, this authorization will expire upon the occurrence of the following event, condition or date:  
  
\_\_\_\_\_  
  
\_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, however, my request of release information will not be fulfilled. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal and state confidentiality rules.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date

\_\_\_\_\_  
If signed by Legal Representative, relationship to patient Signature of Witness

\_\_\_\_\_  
Patient's Date of Birth Patient's Social Security Number