Great Lakes Pediatric Associates, PLLC
3400 Pine Tree Road Suite 102, Lansing, MI 48911
Phone (517) 887-3000/Fax (517)887-6940

Authorization for Disclosure of Protected Health Information (Transfer to GLPA)

Please print all information, the sign and date at bottom.

Patient name: **Date of Birth:**

(Please print)

I authorize disclosure of the protected health information for above patient:

Name: **Address:**
(Printed Parent/Guardian Name)

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

- Alcohol, drug abuse & mental health treatment information protected under the regulations in Title 42 of the Code of Federal Regulations Part 2.
- Information about human immunodeficiency virus-HIV acquired immunodeficiency syndrome- AIDS, and AIDS related complex ARC, as defined by the Dept. of Community rules (1989 Public Act 174).

Person or Organization authorized to receive information: GLPA (address listed above)

Person or Organization to release the records:

Specific Type of information to be disclosed: (mark below)

_____Entire Records _____Immunization Records _____Records from date of service:

This information may be disclosed for the following purpose: (mark below)

_____Continued Care _____Personal Use _____Attorney Use _____Insurance Use

_____Other

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.

I understand that if the person or entity that received the information is not a health care provider or health plan covered by the state or federal privacy laws and regulations, the information described above may be disclosed and no longer protected by those laws and regulations.

I understand that I may revoke this authorization at any time by notifying GLPA by sending a letter to the attention of the Office Manager. However revocation will not be valid if GLPA has taken action in reliance on this authorization.

This authorization expires 90 days from the date of the signature below unless otherwise requested.

Printed name of patient or patient's representative **Relationship to minor**

Signature of Parent or Legal Guardian of minor **Date**

GLPA has verified the identification of patient's representative:
Person known to staff_____ Driver's license/State ID_____ Other

Patient has appointment on: **Please return records by:**