Great Lakes Pediatric Associates
3400 Pine Tree Road, Suite 102
Lansing, MI 48911
Tel (517) 887-3000
Fax (517) 887-6075

Authorization for Disclosure of Protected Health Information

Patient Name_____Birth Date_____

Address_____Phone No._____

1. I authorize Great Lakes Pediatric Associates to make a disclosure of the protected health information on

_____

Patient's name

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:

_____
Name of person to recieve PHI

_____
Streeet Address

_____
City State Zip

3. Specific Type of information to be disclosed. (circle below)
Entire Record Immunization Records Records from visit on_____

Other_____

4. This information may be disclosed for the following purpose: (circle below)
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 redisclosed and no longer protected by those laws and regulations

7. I understand that I may revoke this authorization at any time by notifying Great Lakes Pediatrics in writing by sending a letter to the attention of the office manager. However, the revocation will not be valid if Great Lakes Pediatrics has taken action in reliance on this authorization.

8. This authorization expires 365 days from 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

Great Lakes Pediatrics has verified the identification of patient's representative

__ Person known to staff __ driver's license/state identification other_____