# Dearborn Pediatrics

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## AUTHORIZATION TO RELEASE/REQUEST MEDICAL RECORDS INFORMATION

Patient Name: _____

Address/City/State/Zip: _____

Phone:_____ Birth Date: _____ Gender: M F _____

### Current Office or Clinic:

_____ Phone_____

_____ Fax _____

_____

_____

### Transferring to:

_____ Phone _____

_____

_____ Fax _____

By my signature below, I _____

hereby authorize the above listed entity (herein referred to as the "Practice"), to release or to request "Protected Health Information" (PHI) contained in my medical records at the above listed physician office/location/institution. I understand that I have the right to inspect or copy the PHI that will be used or disclosed pursuant to the Authorization. I understand that the Practice will not condition any aspect of my treatment, payment, or enrollment in the health plan or eligibility for benefits on whether or not I sign this Authorization. I understand that I am under no obligation to sign this Authorization. I understand that the Practice may receive compensation for the uses and disclosures of the PHI which I have authorized.

**The purpose for the disclosure:**
The PHI information which may be disclosed is limited to: _____

records concerning my illness and/or treatment during the period of _____

In accordance with Act 174, Section 5131, **I do authorize** **I do not authorize** the release of records regarding HIV Infection, AIDS related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), and/or serious communicable diseases.
In accordance with Title 42 of the Code of Federal Regulations **I do authorize** **I do not authorize** the release of records regarding drug/alcohol abuse.

The Physician, Facility, and their employees are released from legal responsibility or liability for the release of the above information (PHI) to the extent indicated and authorized herein. The recipients of the enclosed information are not authorized to use PHI for any purpose other than that for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from me or my legal guardian to do so. This Authorization is valid for 90 days from the date of signature unless otherwise revoked. I understand that this authorization may be revoked in writing at any time by my signing the revocation section below and returning it to The Practice unless: a) The Practice has previously acted in reliance on this Authorization; b) or if this Authorization was executed as a pre-condition to obtaining insurance coverage, other law provides that the insurance company has the right to defend the claim pursuant to the insurance policy. By my signing this Authorization, I acknowledge that I have read and comprehend this Authorization. Further, I give my authorization to The Practice to use or disclose my PHI in accordance with the terms of the Authorization.

_____ _____
Patient/ Parent of a Minor Patient or Legal Guardian**/ Date Witness Signature/ Date