AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Not for Psychotherapy Notes)

Patient Name _____ Date of Birth _____

Patient Address _____

Street City State Zip Code

Patient Phone Number _____

I authorize _____

Healthcare Facility/Physician Office Phone Number Fax Number

to release information contained in my medical record (including, if applicable, information about HIV/AIDS infection, substance abuse treatment, mental health services) to:

SG PEDIATRICS OF LAKE ORION
1455 S. LAPEER RD. STE. 134
LAKE ORION, MI 48360
248-683-3385 FAX 248-690-7389

Specific Type of Information to be disclosed:

__ Discharge Summary
__ History & Physical
__ Consultations
__ Lab Results
__ X-ray Report
__Other
__ Other (Specify _____)
__ Operative Report
__ Pathology Report
__ Newborn Screen
__ All Records

The purpose and need for such disclosure:

_____

_____

For mental health records, or records pertaining to HIV/AIDS: Please include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to SG Pediatrics of Lake Orion. We may have already released the information based on your original authorization. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

Your protected heath information will be disclosed as specified in this Authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

_____ _____

Signature of Patient/Parent/Personal Representative Date

_____ _____

Relationship to Patient Print Name