LAPEER PEDIATRICS, P.C.

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name:_____ Birth Date:_____

Patient Address:_____

Social Security #:_____Phone #:_____

- By signing below, I hereby authorize:_____
  to release my health information, as more specifically described below, to be used or disclosed (this health information is referred to herein as "Protected Health Information") including if applicable, information about HIV infection, information about substance abuse and information about mental health services
- The specific name and address to whom my Protected Health Information may be released:
  Lapeer Pediatrics PC
  1083 Suncrest Dr,SteA. Lapeer MI 48446
- I understand that the purpose of the use or disclosure shall be: _____
  _____
- Specific Information to be disclosed:_____
  _____
- This Authorization shall expire on: _____
- I understand that I have the right to revoke this Authorization, except if action has already been taken in reliance upon this Authorization.
- I understand that I may revoke this Authorization by submitting a request in writing.
- I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____ _____

Signature (Patient) Date Signature (Authorized Representative) Date

_____

Printed

Description of Authorized Representative's authority to sign for the patient:_____