Capital Area Pediatrics
3937 Patient Care Drive, Suite 101
Lansing, Michigan 48911
(517) 394-6484 fax (517) 394-7785

Authorization for Disclosure of Protected Health Information

Patient Name_____ Birth Date_____

Address_____ Phone No._____

1. I authorize disclosure of the protected health information on _____ be made by:

Name _____

Address _____

_____

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: **Capital Area Pediatrics**
3937 Patient Care Drive, Suite 101
Lansing, MI 48911

3. Specific Type of information to be disclosed.
☐ Entire Record ☐ Immunization Records ☐ Records from visit on_____

☐Other_____

4. This information may be disclosed for the following purpose:
☐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 Capital Area Pediatrics in writing by sending a letter to the attention of the office manager. However, the revocation will not be valid if Capital Area 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 child

_____ _____
Signature of patient or patient's representative Date

Capital Area Pediatrics has verified the identification of patient's representative
☐ Person known to staff ☐driver's license/state identification ☐other_____