Pediatric Associates of Dearborn

Health Information Release Authorization

I, _____
(Print Patient Name/D.O.B) (Telephone Number)

_____
(Address)

Authorize_____
(Name of Facility Releasing Medical Information)

_____
(Address)

To release information contained in patient records, including as applicable information about communicable diseases and infections, as defined by the State and Michigan Department of Consumer & industry (MDCIS) (which include venereal disease "VD"tuberculosis "TB" human immunodeficiency virus "HIV" acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC" Alcohol and drug abuse treatment information protected under the regulation in 42 Code of Federal Regulation, Part 2. Psychological services and social services information including communications made by me to social worker or psychologist to the individual or organizations listed below, only under the conditions listed below:

1. Name and Address of Receiver:
   _____
2. Specific type of information to be disclosed (Include Date(s) of service):
   _____
3. The purpose and need for such disclosure:
   _____

4. I understand that I have the right to revoke this authorization at any time except as noted below. I understand that if I revoke this authorization, I must do in writing and present my writer revocation to the appropriate department facility that was authorized to release information . I understand that the revocation will not apply to information that has been already released in response to this to this authorization or where OHI facility has acted in reliance upon this authorization. I understand that revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. The right to revoke is also discussed in OHI Privacy Notice.

   Unless otherwise revoked, this authorization will expire upon the following event condition or date:

5. I understand that authorizing the disclosure of this health information is voluntary . I can refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with a potential for an authorization re-disclosure are an information may no longer be protected by Federal and State confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Signature of Witness