BAY PEDIATRIC CLINIC, P.C.

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Bay City, MI 48708
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Authorization for the Release of Protected Health Information

I Authorize Bay Pediatric Clinic, P.C. to release health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions. I understand that Michigan law allows a reasonable fee for the requested copies of medical records.

Patient Information:

_____ _____/_____/_____ _____
Name Date of Birth Address

_____ _____/_____/_____ _____
Name Date of Birth City, State, Zip Code

_____ _____/_____/_____ (____)_____
Name Date of Birth Phone

Information to be disclosed:

_____ Any and all medical records

_____Other (please specify):_____

_____

Purpose for Disclosure:

_____Continuation of medical care _____ Other:_____

Release information to:

_____
Name

_____
Address

_____
City, State, Zip Code

(____)_____ (____)_____
Phone Fax

Release information from:

_____
Name

_____
Address

_____
City, State, Zip Code

(____)_____(____)_____
Phone Fax

_____**Please release information to**:
Bay Pediatric Clinic, P.C.
2110 16th street
Bay City, MI 48708

_____**Please release information from:**
Bay Pediatric Clinic, P.C.
2110 16th street
Bay City, MI 48708

I understand that I may revoke my authorization at any time. The exception to this is if the authorization has already been acted upon. If I want to revoke my authorization, the recipient has non duty to protect its' confidentiality. The recipient may re-disclose the information as he/she wishes. I cannot be refused treatment if I choose not to sign this form. I understand that if I am authorizing the release of protected health information not created by Bay Pediatric Clinic, P.C., the accuracy and completeness of those records created by other providers cannot be verified.

Signature:_____ **Date:**_____/_____/_____ **Expiration Date:**_____/_____/_____
Patient/Legal Representative/Parent (if left blank, this authorization will expire 6 months from today)
(if you are signing as a person representative of the patient, describe below your relationship to the patient and your source of your authority to sign this form)