Lossio Pediatrics, PLLC

Release of Information Authorization

I authorize the use or disclosure of the below named individual's health information as described in this document.

The following Individual or Organization is authorized to make the disclosure: _____

The type of Information to be used or disclosed : __Consultation Reports __EKG's __X-Ray Reports

__Laboratory Reports __Discharge Summaries __Emergency Records __Operative Reports

__History&Physicals __Pathology Reports ___Entire Record

I understand that the information in my Health Record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following: **Lossio Pediatrics, PLLC**
245 Warwick Dr., Ste D Alma, MI 48801

__**Self** __**Other**_____

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 the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____.
If I fail to specify an expiration date, event or condition, this authorization will expire in six(6)months from date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need to sign this form in order to assure treatment. I understand that I may inspect a copy of the the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization.

Patient Name:_____DOB:_____Phone:_____

Mailing Address:_____City:_____State:_____Zip:_____

Patient/Parent Signature:_____Date:_____

Staff Signature:_____