Authorization Form for Patients 18 years+

Patient Name: _____ DOB: _____

I (Patient's name)_____give permission to

Hereby authorize disclosure of my protected health information to include information about my billing, condition, treatment and prognosis to the following individuals.

If any of the below boxes are unchecked you are giving Great Lakes Pediatric Associates PLLC additional specific consent to disclose the below information that we may keep about you.

- ❑ Alcohol or drug abuse, or mental health treatment information under Title 42 of the Code of Federal Regulation Part II.
- ❑ Serious communicable and infectious diseases as defined by the Michigan Department of Public Health Code 1989, Act 174 which includes venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), and hepatitis.
- ❑ Records and reports sent to Great Lakes Pediatric Associates PLLC from other health care providers, including hospitals and physicians.

Revocation of consent: This consent is subject to revocation at any time except to the extent action has been taken in reliance upon this consent. Any revocation of consent must be made in writing and delivered to this office at the above address.
This authorization is valid from the date of signature until written notification is given to cancel this request.

(List Name and Relationship)

_____

_____

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_____

This authorization is valid from the date of signature until written notification is given to cancel this request.

_____

Patient's Signature Date