Great Lakes
Pediatric Associates PLLC

Authorization for Disclosure of Protected Health Information /Medical Records Release
Including Confidential and Restricted Confidential Information

Patient Name _____ Date of Birth _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Work Phone Number _____

I authorize and request the described information to be disclosed under the following conditions:

1.Name of persons or organizations to provide information (Include address & phone number)

_____

2. Name of persons or organization to receive information

Great Lakes Pediatric Associates PLLC
3400 Pine Tree Rd. Suite 102 Lansing MI 48911
Phone: (517) 887-3000 Fax: (517) 887-6075

3. The purpose or need for such disclosure:

- ❑ Transferring into care with Great Lakes Pediatric Associates PLLC
- ❑ Transferring to new Primary Care Provider (Doctor's Office).
- ❑ Personal Needs
- ❑ Other: Specify _____

4. Specific "Confidential" information to be disclosed and time frame of information to be included:

Check all that apply: ❑ Entire Record ❑ Immunization Record ❑ Records from Date of Service:

5. If you do not wish any of the following "Restricted Confidential" information to be disclosed, please check the box(es) below next to the item(s) you wish not disclosed as part of this request**. 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.

6. 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.

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

_____ _____

Printed Name / Signature Date