John A. Boyle, DO, FAAP, FACOP
Roberta A. Bobal-Savage, MD, FAAP
Helen S. Economy, MD, FAAP
Michael J. Hornik, DO, FAAP
Michelle D. Ober, MD, FAAP
2300 Haggerty Road, Ste. 2110
West Bloomfield, MI 48323
Phone: 248-926-1411, Fax: 248-926-5338

PATIENT AUTHORIZATION FOR PRACTICE TO OBTAIN PROTECTED HEALTH INFORMATION FROM THIRD PARTIES

Name of Patient(s) Date of Birth

_____

_____

_____

_____

By signing this authorization, I authorize Pediatric Care Corner, P.C. to obtain certain protected health information (PHI) about me or my child(ren) from the party or parties listed below. This authorization permits Pediatric Care Corner, P.C. to obtain information from:

Name of Doctor/Practice/Facility:_____

Phone:_____Fax:_____

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.):

☐ Immunization Records ☐ Growth Charts ☐ Records From Last Two Years ☐ All Records

☐ Other: Please specify requested records

_____

_____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Pediatric Care Corner, P.C. has acted in reliance upon this authorization. My written revocation must be submitted to Pediatric Care Corner, P.C.'s Privacy Officer at 2300 Haggerty Road, Suite 2110, West Bloomfield, MI 48323.

Optional: Reason for transferring to this practice

_____Insurance change _____Moving _____Dissatisfaction with practice _____Other

_____ _____
Print Name of Parent, Patient or Legal Guardian Relationship to Patient

_____ _____
Signature of Parent, Patient or Legal Guardian Date