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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient(s) DOB

____
____
____
____

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

____
____
____

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.):____
____
____

This authorization will expire on______________________(one year from today's date if left blank) Expiration Date

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 HIPAA 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, West Bloomfield, MI 48323. **WE CHARGE A FEE FOR COPIES. 0-20 PAGES: $10, PLUS POSTAGE. 21-50 PAGES: $20 PLUS POSTAGE. GREATER THAN 50 PAGES: $20 PLUS $.20/PAGE OVER 50, PLUS POSTAGE. IF YOU CHOOSE TO PICK UP YOUR RECORDS AT OUR OFFICE THERE WILL BE NO POSTAGE FEES INCURRED.**

Optional: If transferring to a new practice, the reasons include:

_____Insurance change______Moving ______Dissatisfaction with practice _____Other

Signed by: ____________________________________ ______________________
Signature of Parent, Patient, or Legal Guardian Relationship to Patient

____________________________________ ______________________
Print Name of Parent, Patient, or Legal Guardian Date