John A. Boyle, DO, FAAP, FACOP
Roberta A. Bobal-Savage, MD, FAAP
Helen S. Economy, MD, FAAP
Matthew 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

Patients 18 years or older Authorization to Release Healthcare Information to Parent/Care Giver

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security #: _____

Patient's Cell Phone: _____

I request and authorize Pediatric Care Corner P.C. to release healthcare information of the patient named above to Parent/Care Giver:

Name: _____

Address: _____

City, State, Zip: _____

This request and authorization applies to:

☐ All healthcare information including Lab results, and Diagnostic Imaging.

☐ Other (please specify): _____

Sexually Transmitted Disease (STD) includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of the results of my STD, HIV/AIDS testing, Pregnancy testing, whether negative or positive, to the person(s) listed above.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Yes No I understand that test orders will be visible on my billing statements and insurance explanation of benefits, and will be visible to my authorized parent/caregiver if they are listed below as financially responsible.

Financial Responsibility/Billing Statements should be sent to:

Name: _____ Relationship: _____

Patient Signature: _____ Date Signed: _____

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