Birmingham Pediatrics + Wellness Center Patient Authorization For Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Michigan Law. Birmingham Pediatrics + Wellness Center may not use or disclose your individually identifiable health insurance without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. ***Form must be filled out completely.***

I hereby authorize _____ to release health information of:

Practice Name

Patient Name:_____ Date of Birth: _____

Printed Name

Dates of Service to Release:_____ **or** ☐ Entire Medical Record (Mark an X in box)

Reason for Release:_____

(Reason for release MUST be noted on this form)

Medical Records are to be released to: (Please print this entire section)

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I understand that the recipient of this medical information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusions: (Please initial after section(s) if you want section(s) excluded)

Substance Use/Abuse_____, Mental Health/Psychiatric_____, HIV/AIDS_____, Sexually Transmitted Diseases_____,

Other_____:_____

Write out description of other exclusion

This authorization is effective this date: ____/____/_____ thru ____/____/_____ (Dates must be specific and no longer than 6 months)

Authorized Signature: _____

Printed Name: _____ Relationship to Patient: _____

If this form is completed by someone other than the patient please print your address below:

Street Address: _____

City: _____ State:_____ Zip Code:_____

I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider, or health plan covered by HIPAA, the information used or disclosed as described above may be disclosed, in turn by the above recipient and no longer protected by HIPAA. However, other state or federal law may prohibit the recipient from disclosing specifically protected information, such as substance abuse treatment information, HIV/AIDS related information and/or psychiatric/mental health information.