MI PEDS

Michigan Pediatric Endocrine & Diabetes Services

HIPAA RELEASE *(age 18+)*

PATIENT INFORMATION (PLEASE PRINT):

Patient Name: _____ Date of Birth: _____

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CONSENT FOR RELEASE OF INFORMATION *(Choose ONE of the two options below)*:

*NOTE: Patients 18 years of age and older **MUST** consent below for any information to be shared with parents.*

☐ I give Michigan Pediatric Endocrine & Diabetes Services (MI PEDS) permission to release my information, including:

- ☐ Entire medical record
- ☐ Blood Tests
- ☐ X-rays
- ☐ Appointment Details
- ☐ Billing Information

To the following individuals:

Name & relationship to patient: _____

Name & relationship to patient: _____

Name & relationship to patient: _____

Name & relationship to patient: _____

Name & relationship to patient: _____

☐ There are no other individuals to whom Michigan Pediatric Endocrine & Diabetes Services (MI PEDS) has permission to release my information.

Signature:_____ Date: _____

(A signature is required for this consent to be considered valid)

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