

Michigan Pediatric Endocrine & Diabetes Services a division of Michigan Healthcare Professionals

AUTHORIZATION FOR DISCLOSURE OR RELEASE OF MEDICAL RECORD INFORMATION

Michigan Pediatric Endocrine & Diabetes Services is authorized to disclose information about: PATIENT NAME: (please print): ______ DATE OF BIRTH: _____ PATIENT ADDRESS: Please release a copy of my medical records to: Recipient's Name Recipient's Address Recipient's City, State, ZIP Recipient's Phone Number AND Fax Number Requested information: _____ Covering the period from: ______ to _____ to _____ I hereby authorize Michigan Pediatric Endocrine & Diabetes Services (MI PEDS) to disclose my health information for the purposes noted above. I understand that once such information has been disclosed to the intended recipient, that (MI PEDS) cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that this authorization is effective for twelve (12) months or until revoked in writing. I am aware that the record to be disclosed pursuant to this Authorization may contain the following subject matter and I am authorizing the release of such highly sensitive information unless specifically excluded below. - Alcohol/Drug use, abuse and/or treatment -- Treatment for mental illness and/or social services communications Treatment or testing for HIV/AIDS -- History of venereal of other communicable disease(s) I am requesting that the following information to be excluded from this release: FEES FOR PAPER COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. If there is a fee, you will be required to pre-pay for the copies. THIS FORM MUST BE COMPLETED IN FULL BEFORE SIGNING – Patient must also sign if more than 13 years of age. Date: _____ (Signature of Patient (if 18 years of age or older), Parent, or Guardian) Date: _____

(Signature of Patient - if 13 years of age or older)