Authorization For use or Disclosure of medical Record Information TO / FROM

Patient Information

Patient Full Name: ______________________________

Date of Birth: ______________ Phone#: ______________________

Patient Address: ______________________________

City: ______________________ State: ________ Zip: ____________

Release Information TO / FROM

I hereby Authorize Macomb Pediatric Associates, P.C. to: ____RELEASE ____ OBTAIN

My / my child's medical record information: ____ TO ____FROM

Name / Facility: ______________________________

Address: ______________________________

City: ______________________ State: ________ Zip: ____________

Phone #: ______________________ FAX # is required: ______________________

Purpose of this Request:

____Personal ____Legal ____Insurance ____Other: ______________________

____Transfer of Care & Reason: ______________________

The released records may contain information regarding some of the following:

Communicable disease and infection as defined by statute and Michigan Department of Public Health Rules (which include Venereal Disease "VD", Tuberculosis "TB", Hepatitis B* Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS", and AIDS Related Complex "ARC"). Substance abuse treatment protected by the regulations in 4 Code of Federal Regulations (CFR), Part 2. Mental health treatment records, psychological services and Social Services information, including communications made by the Parent and/or Guardian, to a Psychologist, Social Worker, Nurse or other Provider.

Information to be Released

____ I understand I will be invoiced at the allowable MI Statue rate. Comment: ______________________

____ Please provide my entire medical record. ____ Specific dates ONLY: ______________________

Requested FROM / TO MAIL TO:

27070 Hoover Rd, Suite A
Warren, MI 48093
(586) 573-9090

Or

39200 Garfield Rd suite E
Clinton Twp, MI 48038
(586) 263-4010

All outgoing medical records that exceed 15 pages, can NOT be faxed and they will be mailed.

Authorization to Release Protected Information. Please read and initial the following:

A. I understand, as set forth in the patient's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, anytime by sending notification to the Privacy Officer. initial_____

B. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information. initial_____

C. I understand that I have the right to refuse to sign this authorization or to inspect my protected health information to be used or disclosed as permitted under Federal and State laws. initial_____

D. I understand the practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide authorizations for the requested use or disclosed. Further, if the practice receives payment for obtaining this information, I understand I will be notified. initial_____

E. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. initial_____

______________________________ ______________

Signature of: Parent / Guardian / Adult Patient Date

This Request received on: ____________ This Request FAXED on: ____________

2024 MPA MEDRECREL FORM