Phone: 586 731 1500
Fax: 586 731 1363

Pediatric & Adolescent Care Associates, P.C.
43184 Dequindre Rd, Ste 208
Sterling Heights, MI 48314

Health Information Release Authorization

Patient Full Name: _____
Date of Birth: _____ Sex: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

I, _____, hereby authorize _____, its director or agency to release information contained in the medical record of this patient (identified above), which includes information that may be stored in a paper and/or electronic format. This includes information concerning human immunodeficiency (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC), if any, protected under Michigan Public Act: 174 of 2989, as amended and substance abuse information, if any, protected under 42 Code of Federal Regulations, Part 2 and social and psychological services information, if any, including communication made to a social worker or psychologist, if any to the individual(s) or organization(s) and only under the conditions listed below:

1. Name or title of person or organization and address to who is to be:

Disclosed To:
Pediatric & Adolescent Care Associates, P.C.
43184 Dequindre Rd Ste 208
Sterling Heights, MI 48314

Requested From:
_____
_____
_____

2. The purpose or need for such disclosure:
   - ❑ Personal Use
   - ☑ Continuation of Care
   - ❑ Attorney
   - ❑ Insurance
   - ❑ Workman's Compensation
   - ❑ Disability
   - ❑ Other: _____

3. Specific information to be disclosed/obtained as related to: (indicate date of service)
   - ❑ ER Memo: _____
   - ❑ Outpatient Visit: _____
   - ❑ X-ray/Labs: _____
   - ❑ Discharge Summary : _____
   - ❑ Immunizations: _____
   - ☑ Entire Record: _____
   - ❑ Other: _____

4. This authorization is valid only if received by Pediatric & Adolescent Care Associates within 90 days of the date signed. I may revoke this authorization anytime. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released persistent to this authorization.

5. Information used/disclosed may be subject to re-disclosure.

6. Pediatric & Adolescent Care Associates and/or its copying services reserve the right to charge for processing and copying of information.

Signature: _____ **Relationship:** _____
Date: _____

Witness Signature: _____
_____