KIDS CREEK CHILDREN'S CLINIC

Authorization for Release of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. **I understand that I must provide a copy of my driver's license or proof of custody if needed of my minor child.**

Patient(s) Name: _____ Patient(s) Date of Birth: _____
Address: _____ Phone: ( ) _____

Persons/Organization providing the information:

Kids Creek Children's Clinic
5024 North Royal Drive
Traverse City, MI 49684
231-935-0555 (phone)
231-935-0562 (Fax)

Persons/Organization receiving the information:

_____

_____

_____

Fax:_____

Information to be released:

- □ The last 1 year of medical records or any pertinent records
- □ A specific portion of the record: From date of service _____ to _____
- □ Please indicate any limitation on the information to be released: _____
  _____

This information may include any of the following, unless identified immediately:

a) Alcohol or drug abuse, or mental health treatment information protected under Title 42 of the Code Federal Regulations Part II.

b) Serious communicable and infectious diseases as defined by the Michigan Department of Community Health Code, 1989, Act 174, which includes Venereal Disease, Tuberculosis, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS - Related Complex (ARC), and Hepatitis.

c) Records and reports sent to our office or to Dr./Drs. from other physicians, clinics, hospitals or other health, medical, or human service providers.

Revocation of this consent is available at any time, except to the extent that release of information has already occurred in reliance upon this consent.

The duration of this consent without express revocation shall expire 180 days from the date signed.

I authorize and request that any and all medical information as indicated above be released according to the terms outlined within this agreement.

_____ _____
Authorizing Signature Date Witness Signature Date

_____ _____
Print Name and Relationship to Patient Witness Printed Name