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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned hereby authorizes Western Michigan Pediatrics, PC to disclose, for the purpose other than treatment, payment, or health care operations, the protected health information of:

____
Patient Name *Date of Birth*

Protected health information to be disclosed:

_____Entire medical record, INCLUDING information related to the treatment for substance abuse or Dependency: Psychiatric or mental health treatment; or HIV or sexual abuse information. $20 fee

_____Entire medical record, EXCLUDING information related to the treatment for substance abuse or Dependency: Psychiatric or mental health treatment; or HIV or sexual abuse information. $20 fee

_____Last Well Child Exam, Immunization Record, Problem List, Medication List, Allergy List, and Growth Chart. These records are provided at no charge.

_____Record of Immunizations only.

_____Other____

Reason for transferring records: *(Optional)*
_____Please describe____
_____Would you like a follow-up call from the office manager? If yes, provide your phone number__________________

Physician, individual, organization, or other health care provider to receive this information:

____
Name
____
Address
____
City, State, Zip
_______________________________________ _______________________________________
Telephone Fax

I am:
_____ The patient (if age 18 or over).
_____ An authorized representative of the patient (please provide proof of authority).
_____ A parent of a patient who is under the age of 18.
_____ The legal guardian of the patient (please provide proof of guardianship).

________________________________ ______________________________ ____________
Signature *Printed Name* *Date*