

Bright Start Pediatrics

1761 W. M-43 Hwy Suite #2 Hastings, MI 49058

P: (269) 818-0070

F: (269) 818-0044

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

I, the undersigned authorize you to furnish a copy of the following medical records to _____

- | | |
|--|---|
| <input type="checkbox"/> Laboratory Data | <input type="checkbox"/> Hospital Notes |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> ER Notes |
| <input type="checkbox"/> Progress/Doctor's Notes | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Operative Reports, Findings and Complications | <input type="checkbox"/> Immunization Records and Growth Charts |
| <input type="checkbox"/> Other Documents (please specify) _____ | |

Physician/Practice releasing records:

Name: _____
Address: _____
City/State/Zip: _____
Phone: (____) _____
Fax: (____) _____

Physician/Practice to receive records:

Name: Bright Start Pediatrics
Address: 1761 W. M-43 Hwy Suite #2
City/State/Zip: Hastings, MI 49058
Phone: (269) 818-0070
Fax: (269) 818-0044

I authorize the release of these medical records to Bright Start Pediatrics from all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment.

I authorize Bright Start Pediatrics to release my medical records regarding their treatment to relevant healthcare providers, facilities and diagnostic centers involved in the course of my treatment.

I specifically consent to the disclosure of records to Bright Start Pediatrics that may contain alcohol/drug/substance abuse information. I specifically consent to the disclosure of these records by Bright Start Pediatrics to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____ (initials)

I specifically consent to the disclosure of records to Bright Start Pediatrics that may contain HIV test results or diagnosis of AIDs and AIDs related conditions. I specifically consent to the disclosure of these records by Bright Start Pediatrics to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____ (initials)

I specifically consent to the disclosure of records to Bright Start Pediatrics that contain mental health information. I specifically consent to the disclosure of these records by Bright Start Pediatrics to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____ (initials)

If not previously revoked, this authorization to use or disclose protected health information will expire TWELVE (12) months from the date of my signature or as otherwise specified by date, event or conditions(s) as Follows: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: Bright Start Pediatrics Attn: Amy Beck, M.D. 1761 W. M-43 Hwy Suite #2 Hastings, MI 49058. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. [If applicable because the authorization is obtained for marketing purposes.]

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority