Brighton Pediatric Center

8550 W. Grand River, Ste 300
Brighton, MI 48116
Tel (810) 220 3700

Authorization for Release of Medical Records TO BPC

RE: PATIENT NAME:_____/_____/_____
(LAST) (FIRST) (MI) (DATE OF BIRTH)

RE: PATIENT NAME:_____/_____/_____
(LAST) (FIRST) (MI) (DATE OF BIRTH)

RE: PATIENT NAME:_____/_____/_____
(LAST) (FIRST) (MI) (DATE OF BIRTH)

I authorize the following Individual or organization to make the disclosure:
Name of Doctor/ Clinic_____
Complete address: _____
_____
Telephone Number: (_____)_____Fax: (_____)_____

TO BE SENT TO : Brighton Pediatric Center,
8550 W. Grand River Ave, Suite 300,
Brighton MI 48116

INFORMATION TO BE RELEASED:

- ☐ All Records
- ☐ Progress notes/ Physical
- ☐ Lab reports/ X-ray reports
- ☐ Immunization records

I specifically authorize the release of information regarding:

- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ HIV related information (AIDS related testing)
- ☐ Other_____

PURPOSE OF DISCLOSURE

☐Relocating out of area ☐ Changing doctor in area ☐Specialist/ Consultation ☐School
☐Insurance Change ☐Transfer from Pediatric to Adult doctor ☐Second Opinion ☐Legal
☐Other_____

I understand that this authorization will expire **90 days** after I have signed the form. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign.

_____/_____/____ OR _____/_____/_____
SIGNATURE OF PATIENT **DATE** **PARENT/ LEGAL GUARDIAN** **DATE**

BPC