Nuga Pediatrics o.f Lenawee, PLLC.

901 Kimole Lane, Suite B2, Adrian, MI 49221   P: 517-265-198; F: 517-263-1001

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS IT IS COMPLETED IN ITS ENTIRETY.
All information must be filled in and all questions must be answered for release to be processed.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand 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, and that it may be re-disclosed by the recipient.

Patient Name: ____________________________
Date of Birth: _______ / _______ / ________

Patient Name: ______________________________
Date of Birth: ________ / ________ / _________

Patient Name: ____________________________
Date of Birth: _______ / _______ / ________

Patient Name: ______________________________
Date of Birth: ________ / ________ / _________

Organization To Release Information

Name: ____________________________________
Address: ____________________________________
City/State: ____________________________________
Phone: ________-________-_______________

Organization To Receive Information

NUGA PEDIATRICS LENAWEE
901 Kimole Lane, Ste B2,
Adrian, MI 49221,
P: 517-265-1981   F: 517-263-1001

I authorize this disclosure of Protected Health Information for the following reason: (please check one)

Is this Authorization for the purpose of transferring your care (including vaccine records)? ____ NO ____ YES
Is this Authorization to have records for your own use? ____ NO ____ YES
Is this Authorization for specific records only? ____ NO ____ YES
If yes, specify **what** records and **date of service:** ____

I understand that I have no obligation to disclose information from my record and understand that I may revoke this authorization at any time in writing; except to the extent that action based on the consent has already been completed. I fully understand the contents of this authorization and I do voluntarily consent to the release of the information stated. My signature authorizes release of information by routine mail or fax.

⊗ ____ ___/___/_____ ____________________
Signature of Parent, Legal Guardian, or Patient if 18 years old **Date** **Relationship to Patient**

____ ________-_______-________________
Print Your Name **Your Contact Phone Number**

(You must also sign below if any ADD or ADHD issues are addressed in the chart)

If this information being disclosed to the above person, organization or agency is from records whose confidentiality may be protected by the **MI Drug and Alcohol Act () and/or the MI Mental Health Procedures Act () and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public Law 93-282) and/or Confidentiality of HIV Related Information Act (**this information must be released with a separate signature).

My signature authorizes release of above mentioned information by routine mail or fax.

⊗ ____ ___/___/_____ ____________________
Signature of Parent, Legal Guardian, or Patient if 18 years old **Date** **Relationship to Patient**

This authorization will expire 1 year from the date signed, unless otherwise designated.