MICHIGAN PEDIATRIC
ENT ASSOCIATES, PLLC

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Contact Numbers: ( ) _____ ( ) _____

I authorize the following organization to release information as stated below from the patient health record:

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
☐ Michigan Pediatric ENT, Assoc.	☐ Michigan Pediatric ENT, Assoc.
☐ _____ Organization/Person	☐ _____ Organization/Person
_____ Street Address	_____ Street Address
_____ Phone Fax	_____ Phone Fax

INFORMATION TO BE RELEASED

☐ Entire Record ☐ Dates _____/_____/_____-_____/_____/_____

☐ Other (please specify): _____

Format for Records (please check only ONE box) ☐ MAIL ☐ FAX ☐ PICK UP

PURPOSE OF RELEASE

☐ Legal ☐ Personal Use ☐ Continuation of Care ☐ Transfer to Another Provider ☐ School

☐ Other: _____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by written notification to MPENTA. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it potential for further releases or distribution by the recipient that may not be protected by confidentiality laws
- This authorization will expire 90 days from the date signed by you

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

_____ _____/_____/_____

Signature of Patient or Legally Responsible Party Date

_____

Relationship to Patient, if not signed by patient