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**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE  
 PROTECTED HEALTH INFORMATION**

Name of Patient(s)

DOB

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

By signing this authorization, I authorize Pediatric Care Corner, P.C. to use and/or disclose certain protected health information (PHI) about me or my child(ren) to or for the party or parties listed below. This authorization permits Pediatric Care Corner, P.C. to use or disclose to:

\_\_\_\_\_  
 \_\_\_\_\_

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.):

\_\_\_\_\_  
 \_\_\_\_\_

This authorization will expire on \_\_\_\_\_ (one year from today's date if left blank)  
 Expiration Date

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Pediatric Care Corner, P.C. has acted in reliance upon this authorization. My written revocation must be submitted to Pediatric Care Corner, P.C.'s Privacy Officer at 2300 Haggerty Road, West Bloomfield, MI 48323. **WE CHARGE A FEE OF \$40 FOR COPIES WHICH IS PAID IN ADVANCE. IF YOU CHOOSE TO ONLY HAVE THE IMMUNIZATION RECORDS, GROWTH CHART AND A LIST OF VISITS (NO NOTES) THERE IS NO CHARGE.**

Optional: If transferring to a new practice, the reasons include:

\_\_\_\_ Insurance change \_\_\_\_\_ Moving \_\_\_\_\_ Dissatisfaction with practice \_\_\_\_\_ Other

Signed by:

\_\_\_\_\_  
 Signature of Parent, Patient, or Legal Guardian

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Print Name of Parent, Patient, or Legal Guardian

\_\_\_\_\_  
 Date