HOLLAND PEDIATRIC ASSOCIATES, PLC

926 Washington Ave., Building C • Holland, MI 49423 • www.hollandpediatrics.com • P: 616.393.0166 • F: 616.393.0167

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ADULT PATIENTS (18 YEARS OF AGE OR OLDER)

Upon your 18th birthday, you are an adult by Michigan law. As of age 18, you have the same HIPAA rights that every adult is provided. Therefore, if you would like to share your medical information with anyone (i.e. mom, dad, grandparent, etc.), you will need to give authorization. This form is an authorization that will permit Holland Pediatric Associates, PLC to release your medical information to a designated person. This form is to be completed and signed by the adult patient who is authorizing the designated person to access medical information.

PATIENT INFORMATION

Legal Name: _____ Birthdate: _____
First Name Last Name

Preferred First Name: _____ Preferred Pronouns: _____

☐ YES!

I would like to give authorization to a designated person or people.

DESIGNATED PERSON(S)

Please list the person(s) you would like to give authorization to:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone Number: _____ Phone Number: _____

Relationship to Patient(s): _____ Relationship to Patient(s): _____

AUTHORIZATIONS

I authorize the person(s) listed above access to the following information from Holland Pediatric Associates, PLC:

☐ ANY AND ALL MEDICAL INFORMATION
I authorize the person(s) listed above access to ALL medical information from Holland Pediatric Associates, PLC. This includes medical records, appointment information and prescription pick-up.

☐ APPOINTMENT INFORMATION ONLY
I authorize the person(s) listed above access to appointment information from Holland Pediatric Associates, PLC. This includes making appointments, cancelling appointments and receiving confirmation of appointments.

☐ NO!

I do not authorize any information to be released to anyone.

SIGNATURE

I understand that I may revoke any authorization at any time by notifying Holland Pediatric Associates, PLC in writing. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this authorization. I understand that the information used or disclosed pursuant to this authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

NOTE: Parents cannot sign for patients that are 18 years of age or older. ONLY the adult patient (18+ years of age) can sign.

Name (printed): _____ Birthdate: _____
First Name Last Name

Signature: _____ Today's Date: _____