Traverse Area Pediatric and Adolescent Clinic

Patient Name _____ DOB _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Release healthcare information of the patient named from

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Release healthcare information of the patient named above to

Traverse Area Pediatric and Adolescent Clinic
4020 West Royal Drive
Traverse City, MI 49684

Phone 231-421-8099
Fax 231-421-8599

This authorization for release of information covers the period of healthcare from _____ to _____

- I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS and treatment of alcohol or drug abuse)
  - Other (Please Specify) _____

  OR
- I authorize the release of my complete health record with the exception of the following information:
  - Mental health records
  - Communicable diseases (including HIV / AIDS)
  - Alcohol / drug abuse treatment
  - Other (Please Specify) _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims, or other purposes as I may direct.

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this Authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient / Parent / Guardian (Circle One) Today's Date

_____

Printed Name of Signee