Serenity Pediatrics

71 E. Long Lake

Bloomfield Hills, MI 48304

Phone #: 248-533-0000 Fax #: 248-385-5541

Authorization to Release or Disclose Protected Health Information

Patient's Name: ______________________________ Date of Birth: ____/____/______ Date of Request: ___________________

Address: ____ Day Time Phone: (______) ______________________

Please list where Serenity Pediatrics is to request medical records **FROM**:

Facility/Office: __________________________________ Fax Number: ______________________________

Address: ____ Phone Number: ___________________________

City, State: ______________________________________

Dates of Service: ____

Reason for Request: ____

The following information is to be disclosed to Serenity Pediatrics: (Please send **ONLY** the items circled below.)

Please send **ALL** records unless specified below.

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Please send the information via fax or mail to Serenity Pediatrics: (Circle One)

Fax: 248-385-5541 Mail: 71 E. Long Lake

Bloomfield Hills, MI 48304

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.

By signing the form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Serenity Pediatrics of any and all accountabilities concerning these medical records.

____ ____________________________________

Signature of Patient or Legal Representative Date

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If signed by legal representative, relationship to patient