Merrillwood Pediatrics
27332 Woodward Avenue, Suite 100 • Royal Oak, Michigan • 48067
Office 248.543.1545 • Fax 248.543.8538

Medical Record Release Form

Individual's Name (please print): _____ Date of Birth:_____

Individual's Address: _____

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her name and address _____

   _____

   _____

3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

Please indicate your preference regarding disclosure concerning information about alcoholism/substance abuse, HIV/AIDS or mental health:

Yes, disclose this information _____

No, do not disclose this information _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or faculty receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
6. This authorization expires on _____, 20____ OR upon occurrence of the following event that relates to me or is the purpose of the intended use or disclosure of information about me:_____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with Smart Corporation to make copies. You may be required to pre-pay for copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING. Note that a signature is required in two places.

_____	_____	_____
Signature of Individual (The person about whom the information relates)	Date of Individual's Signature	Date of Birth or Social Security Number

OR, if applicable:

_____	_____	_____
Signature of Guardian or Personal Representative of Patient's Estate	Date of Guardian/Personal Representative's Signature	Description of Authority or Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or other signator.