

# Cascade Pediatrics, LLP

5150 Cascade Rd SE Suite B Grand Rapids, MI 49546

P: (616) 940-3168

F: (616) 940-3352

## Authorization for Use or Disclosure of Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- Furnish a copy of the following medical records
- Verbal disclosure of the following medical records

Receiving Party: \_\_\_\_\_ Cascade Pediatrics \_\_\_\_\_ Time Period from \_\_\_\_\_ to \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Laboratory Data                             | <input type="checkbox"/> Hospital Notes    |
| <input type="checkbox"/> Radiology Reports                           | <input type="checkbox"/> ER Notes          |
| <input type="checkbox"/> Progress/Doctor's Notes                     | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Operative Reports, Findings & Complications | <input type="checkbox"/> Entire Chart      |
| <input type="checkbox"/> Other Documents (please specify) _____      |  |

### Physician/Practice releasing records:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_  
Fax: (\_\_\_\_) \_\_\_\_\_

### Physician/Practice to receive records:

Name: Cascade Pediatrics, LLP  
Address: 5150 Cascade Rd SE Suite B  
City/State/Zip: Grand Rapids, MI 49546  
Phone: (616) 940-3168  
Fax: (616) 940-3352

I authorize the release of these medical records to Cascade Pediatrics to all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment. I agree that the information may be faxed for expediency.

I specifically consent to the disclosure as indicated above that may contain the following information:

- Alcohol/drug/substance abuse information \_\_\_\_\_ (initials)
- HIV test results or diagnosis of AIDs and AIDs related conditions \_\_\_\_\_ (initials)
- Mental health information \_\_\_\_\_ (initials)
- Pregnancy information \_\_\_\_\_ (initials)
- Sexually transmitted diseases (STD) information \_\_\_\_\_ (initials)

If not previously revoked, this authorization to use or disclose protected health information will expire TWELVE (12) months from the date of my signature or as otherwise specified by date, event or conditions(s) as follows:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: \_\_\_\_\_. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information 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 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.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. [If applicable because the authorization is obtained for marketing purposes] I have the right to inspect and obtain a copy of the information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority