

Southfield Pediatric Physicians

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West Bloomfield, MI 48322
(248) 661-9100
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Authorization to Obtain Records From an Outside Provider

_____ Patient	_____ DOB	_____ Patient	_____ DOB
_____ Patient	_____ DOB	_____ Patient	_____ DOB

I, _____, as parent, guardian authorize Southfield Pediatrics to
parent/guardian
obtain records from:

Dr.: _____
Address: _____
Phone: _____ Fax: _____

Please mail records to Southfield Pediatrics at address listed above.

I authorize release of the entire medical record including drug, chemical dependency, alcohol abuse, mental health, communicable disease including sexually transmitted disease and any and all other records in accordance with Federal Regulations.

I expressly authorize information concerning the following serious communicable diseases to be released.

HIV

AIDS-Related Complex (ARC)

Acquired Immunodeficiency Syndrome (AIDS)

Parent/Guardian/Patient Signature

Date

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation(42 CFR Part 2 and Public Act 258) prohibit from making further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. This authorization is valid for one year from the date of request unless otherwise revoked in writing to Southfield Pediatric Physicians.