MiKiDS PEDIATRICS

AUTHORIZATION FOR CONFIDENTIAL COMMUNICATION

Is it OK to leave a detailed message including medical information on your voicemail?

☐ Yes ☐ No List Phone # _____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to (other than parent/guardian)

Name _____ Relationship _____ Cell _____

Name _____ Relationship _____ Cell _____

Name _____ Relationship _____ Cell _____

Under Michigan law the information below will be made available to the people listed above ONLY IF I give my approval by checking the box(es) below:

- ☐ Medical Care/Treatment Level of Information _____
- ☐ Billing Information
- ☐ HIV/AIDS or other diseases - tuberculosis, hepatitis, veneral diseases, sexually transmitted diseases
- ☐ Substance abuse services
- ☐ Mental health services
- ☐ Pick up PHI (such as prescription, billing statements, labs, etc.)
- ☐ Other (specify in detail - appointments such as date of service, type of service, level of detail to be released, origin of information, etc.)

_____

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This authorization shall be in force and effect and expires in 12 months or until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: MiKids Pediatrics 4540 Kalamazoo Ave. SE, Grand Rapids, MI 49508. 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 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 pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Parent/Guardian Signature _____ Date _____