Serenity Pediatrics
71 E. Long Lake Rd. Bloomfield Hills, MI 48304
Phone: (248) 533-0000 Fax: (248) 385-5541

Authorization to Share Health Information

By signing this authorization, I, _____ (Print Name), agree/decline to share the following health information:

- ❑ I **AGREE** to share/release all relevant health information, **INCLUDING** release of all of the following special consent information: Human Immunodeficiency Virus (HIV) related illness, testing OR sexually transmitted diseases; Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC); information about alcohol and drug abuse treatment; information about mental health services and social services. In addition, other private information such as pregnancy or contraceptive management information can be shared.
- ❑ I **AGREE** to share/release all relevant health information, **EXCLUDING** special consent areas listed above.
- ❑ I **AGREE** to share/release **ONLY** this specific information:
- ❑ I **DECLINE** to share/release my health information.

I , _____ (Print Name), agree to share my health information with the following individuals involved in my care:

Name of Individual: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone #:_____ Relationship to Patient: _____

Name of Individual: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone #:_____ Relationship to Patient: _____

Privacy Notices:

- If using a parent's health insurance plan for services, Serenity Pediatrics and the insurance company may share information to the policyholder/parent for services you have performed. In addition, if you agree to use your parent's/parents' health insurance, they would receive a bill and have access to your diagnosis. If you pay today with your parents insurance, they may gain access to medical and billing information about your visit.
- This consent will be in effect until you withdraw it in writing.
- If you give permission to share your health information with another person, that person could re-disclose your health information and your information is no longer protected by federal privacy laws.

_____ _____

Signature of Patient/ Printed Name Date