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

Authorization for Release of Protected Health Information

***Please complete all fields and one (1) form per child if multiple records requested.**

Patient Name: _____ Date of Birth: _____ Date of Request: _____

Street Address: _____ Phone Number: _____

By signing this authorization, I authorize the part listed below to use and/or disclose certain protected health information about me/my child. I also understand that I may revoke this authorization at any time, in writing, to the address listed below provided the information has not been released. I understand that the revocation will not apply to any information that has been released. I understand that any disclosure of information carries with it the potential for re-disclosure and that the information

I Authorize:

Provider Name:	
Street Address:	
City, State, ZIP:	
Phone Number:	
Fax Number:	

To Release To:

New Provider Name, Specialist, or Person Receiving Copy:	
Street Address:	
City, State, ZIP:	
Phone Number:	
Fax Number:	

Information to be Release/Requested*: *I understand that information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV). It may include information about behavioral or mental health services or treatment for alcohol and drug abuse.

- ❏ All pertinent medical records
- ❏ Immunization record
- ❏ Lab results- Dates:
- ❏ Imaging results- Dates:
- ❏ Other- Please specify:

_____ _____

Signature of Parent or Legal Representative/ Printed Name Date