KENT PEDIATRICS

4735 West River Dr.
Comstock Park, MI 49321

Patient Name_____Nickname_____Date of Birth_____

Race/Ethnicity_____Male/Female_____

PARENT OR GUARDIAN INFORMATION

FATHER:

Name:_____Date of Birth_____Martial Status_____

Address:_____Social Security #:_____

Employer:_____Primary Phone:_____Alternative Phone:_____

MOTHER:

Name:_____Date of Birth_____Martial Status_____

Address:_____Social Security #:_____

Employer:_____Primary Phone:_____Alternative Phone:_____

Insurance Card Holder's Information:

Primary Insurance Carrier_____Subscriber_____Date of Birth_____

Policy No_____Group No_____

Secondary Insurance Carrier_____Subscriber_____Date of Birth_____

Policy No_____Group No_____

I authorize payment of medical benefits by the insured directly to Kent Pediatrics PC. I also request payment of government benefits directly to the party who accepts assignment.

Signature_____Date_____

Authorization For Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to ***(LIST ANYONE OTHER THAN PARENTS)***:

Name:_____Relationship to Patient_____

Name:_____Relationship to Patient_____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

Medical Care/Treatment **Yes_____No_____**
Billing Information **Yes_____No_____**
Pick up PHI (such as prescriptions, billing statements, labs etc.) **Yes_____No_____**
Other (specify in detail-such as date of service, type of service, level of detail to be released, origin of information etc.

_____

This authorization shall be in force and effect and does not expire 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 : Kent Pediatrics 4735 West River Dr. Comstock Park, MI 49321. 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.

Patient/Parent/Guardian Signature_____Date_____