BELLEVILLE LAKE PEDIATRICS
RELEASE OF BILLING INFORMATION AUTHORIZATION

PATIENT INFORMATION

Patient Full Name: _____

Date of Birth: ____ / ____ / _____

Parent/Guardian Name (if patient is a minor): _____

Relationship to Patient: _____

I, the undersigned patient or the patient's parent/legal guardian/personal representative, authorize Belleville Lake Pediatrics, including its physicians, staff, and billing agents, to disclose billing and payment-related information to the individual(s)/entity(ies) listed below for billing, insurance coordination, payment processing, account management, and related financial communications. Billing information may include protected health information, such as dates of service, procedure and diagnosis codes, and provider names, but only to the extent needed for these purposes.

Authorized Recipient #1: _____ Relationship: _____

Address: _____ Phone:_____ Email: _____

Authorized Recipient #2: _____ Relationship: _____

Address: _____ Phone:_____ Email: _____

Information to Disclose (check all that apply): ☐ Account Balances ☐ Statements ☐ Claims/Payments ☐ EOB Information ☐ Payment History ☐ Collection Status ☐ All Billing Information ☐ Other: _____

Excluded Information: Unless separately and specifically authorized in writing, this authorization does NOT permit disclosure of: (a) substance use disorder records protected by 42 CFR Part 2; (b) HIV/AIDS or other sexually transmitted infection information, which requires specific authorization under MCL 333.5131; (c) mental health information protected by the Michigan Mental Health Code, MCL 330.1748; or (d) genetic information.

Minors' Confidential Services: Under Michigan law, a minor may consent on their own to certain services, such as treatment for sexually transmitted infections (MCL 333.5127) and substance use disorder treatment (MCL 330.1264). Billing information for these services may be subject to additional confidentiality restrictions and may not be disclosed to a parent, guardian, or other recipient except as permitted by law.

Expiration: ☐ 1 Year from Signature ☐ Specific Date or Event: _____ ☐ Until Revoked in Writing (but no later than the date a minor patient turns 18)

If no expiration option is checked, this authorization expires one (1) year from the date of signature. A patient who reaches age 18 must sign a new authorization for disclosures to continue.

Acknowledgments: By signing below, I acknowledge and understand the following:

1. **Voluntary.** This authorization is voluntary. Belleville Lake Pediatrics will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

2. Right to Revoke. I may revoke this authorization at any time by delivering written notice to Belleville Lake Pediatrics. A revocation is effective upon receipt, except to the extent that Belleville Lake Pediatrics has already taken action in reliance on this authorization. Additional information about my right to revoke is described in the Belleville Lake Pediatrics Notice of Privacy Practices.

3. Redisclosure. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations (45 C.F.R. Parts 160 and 164).

4. Limited Scope. This authorization is limited to the billing and payment information identified above and does not authorize the release of medical records, treatment notes, test results, or other clinical information, except to the extent such information necessarily appears on billing statements, claims, or Explanations of Benefits. Release of clinical information requires a separate written authorization.

5. No Financial Responsibility. Signing this authorization does not make the Authorized Recipient financially responsible for the patient's account and does not change the guarantor or responsible party on the account.

6. Copy. I am entitled to receive a copy of this signed authorization.

7. Personal Representative. If I am signing as a parent, legal guardian, or other personal representative of the patient, I represent that I have legal authority to sign on the patient's behalf. Belleville Lake Pediatrics may request documentation of that authority, such as a guardianship order, custody order, or other court papers, before acting on this authorization.

SIGNATURES

Patient (if 18 years of age or older, or an emancipated minor)

Patient (If 18 Years of Age or Older)

Signature: _____

Printed Name: _____

Date**:** ____ / ____ / _____

Parent or Legal Guardian (If Patient Is a Minor or Has a Legal Representative)

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Date**:** ____ / ____ / _____