FORM 3

_____ **("Medical Practice")**

Authorization to Disclose Protected Health Information

Directions: *Type or print all requested information, with exception of signatures on Page 2.*

Patient's Name			**Patient's ID Number (Medical Record No., SSN, Other)**
Street Address			**Patient's Date of Birth** / /
City	**State**	**ZIP**	**Phone** ( ) –

A. INFORMATION TO BE DISCLOSED:

In order to disclose protected health information for any reason other than treatment, payment, health care operations, performing certain insurance functions, or as otherwise required or authorized by law, Medical Practice and its health professionals and staff (collectively the "Practice") must obtain your signed authorization. Complete the following to indicate those items you authorize the Practice to disclose. To authorize the disclouse of all health information which the Practice creates, receives or maintains, check the first box.

I authorize the Practice to disclose the health information checked below concerning my care / the above-named patient. I understand that this information may include, when applicable, information relating to Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), behavioral or mental health services (excluding psycho-therapy notes), and/or information that might identify the above-named patient (directly or indirectly) as having or having had a substance use disorder (as permitted by MCL §330.1748, MCL §330.1262, and/or 42 CFR Part 2).

☐ **All Health Information**	☐ EKG/Cardiology Reports	☐ Diagnostic Test Report	☐ Operation Reports
☐ Physician's Orders	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Consultation Reports	☐ Progress Notes	☐ Patient Allergies	☐ Billing Information
☐ Pathology Reports	☐ Discharge Summary	☐ Radiology Reports & Images	☐ Other_____

_____ **Limited Dates of Service.** If initialed here, I authorize the Practice to disclose the above health information only for the following Dates of Service *(e.g., health information for the past two years. If authorizing disclosure of all Dates of Service, skip.):*

_____

_____

_____ **Exclusions.** If initialed here, I DO NOT authorize the Practice to disclose the following health information concerning the above-named patient:

_____

_____

B. WHO CAN RECEIVE AND USE THE HEALTH INFORMATION:

List the person and/or organization to whom you authorize the Practice to disclose the above-named patient's health information.

_____
AUTHORIZED PERSON / INDIVIDUAL'S NAME

_____
AUTHORIZED ORGANIZATION NAME

_____
STREET ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE NUMBER (INCLUDE AREA CODE) FAX NUMBER (INCLUDE AREA CODE)

CONTINUED »

C. REASON FOR DISCLOSURE:

This disclosure and use is initiated at the request of the individual. (Note: You may state a specific purpose below; however, you are not required to do so).

_____

_____

D. EFFECTIVE TIME PERIOD:

Unless permission is revoked, this authorization is valid for one year from the signature date below or until the following specific date (optional): Month _____ Day _____ Year _____.

E. RIGHT TO REVOKE:

I understand that I have the right to change my mind and to **revoke my permission at any time**. I understand that this must be done by giving written notice stating my intent to revoke this Authorization to the Practice. I understand that any uses or disclosures already made with this Authorization cannot be revoked.

If this Authorization is needed as a condition to obtain health care coverage and I revoke it, I understand that the person and/or organization named under "Who Can Receive and Use the Health Information" who would have received the information may have the right to contest health care coverage claims.

F. SIGNATURE AUTHORIZATION:

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this Authorization, I understand that except as otherwise provided in this Authorization, any disclosure of information carries with it the potential for a re-disclosure by the recipient without my authorization and that the information may not be protected by federal or state privacy laws and rules. I understand I may request a copy of this signed Authorization. I acknowledge that a paper or electronic copy of this Authorization may be relied upon the same as the original document with my wet-ink signature.

Legal Representative's Name *(If applicable)*	**Legal Representative's Relationship to Patient** *(A letter of authority may be requested.)*
Signature of Patient or Legal Representative	**Date** / /
Signature of Witness	**Date** / /