A Patient Centered Medical Home

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Important: All blanks must be completed

Patient Name:____ **Birthdate:**____________________

Address:____**SSN**:_______________________________________

____**Telephone**:__________________________________

Released **FROM:**____________________________________ Released **TO:**____

____________________________________ ____

____________________________________ ____

Specific type of information to be disclosed: ____Any and All Records ____Diagnostic Reports Only ____Laboratory Results Only

____ Immunizations ____Chart Notes Only ____ Consultations Only

Time Period:_____________________________

- Communicable disease and infection information as defined by statute and Michigan Department of Public Health Rules (which includes venereal disease “VD”, tuberculosis “TB”, hepatitis B, human immunodeficiency virus “HIV”, acquired immunodeficiency syndrome “AIDS” and AIDS related complex “ARC”)
- Alcohol and or/drug abuse protected information protected under regulations in 42 Code of Federal Regulations, Part 2
- Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist

The purpose and need for disclosure:____Transfer of Care ____Attorney Request ____Disability ____Workers ’Comp

____Social Security ____Insurance ____ Other____

I understand, as set forth in the practice’s Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

I understand I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.

I understand the Practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of same. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer by protected by federal or state law.

Without expressed written revocation, this consent expires after one year.

____ ____

Signature of ___Patient ___ Personal Representative **Printed name**

Dated__________________________ ____

If Personal Representative, Relationship to Patient