Limited Patient Authorization for Disclosure of Protected Health Information Form 7.31
Please print all information. Form must be signed and dated.

Patient Name: _____ Maiden Name: _____
SSN (last four digits): _____ Date of Birth: _____

Entity Requested to *Release* Information:
Individual/Entity Name: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.
Who will be authorized to *Receive* information (the individual/entity who is to receive your PHI)**:**

Individual/Entity Name: _____

Address: _____

Phone: _____ Fax: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:
☐ office notes dates: _____
☐ radiology reports
☐ Only send the following: _____
☐ lab results, pathology reports
☐ financial history report (previous 3 years only)
☐ disability/FMLA

I authorize the release of health information contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statute and Michigan Department of Health rules, which include venereal disease, Tuberculosis, Hepatitis A, B, C, Human Immunodeficiency Virus(HIV), HIV testing,
- Acquired Immunodeficiency Syndrome(AIDS), and AIDS related complex(ARC)and _____(specify)
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, Part 2.
- Mental Health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
☐ Patient Request
☐ Other (please specify) _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____
Patient or Authorized Representative Signature Date

You have the right to receive a copy of signed authorizations upon request.