



Patient Name _____ Maiden / Other Name _____

Patient Address _____
Street City State Zip

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION –
AMBULATORY SETTING**

I, _____ hereby authorize _____
its Director or Designee, or Health Information Management/Medical Records Department, to release protected health
information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations,
Part 2, if any; behavioral medicine services records, if any, including communications made by me to a social worker or psychol-
ogist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes
venereal disease, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed
below:

1. Name of person(s) or organization(s), to whom information is to be released to:

Name _____
Street Address _____
City _____ State _____ Zip Code _____

I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the
individual or organization named above and its privacy will no longer be protected by the law.

2. The authorized person *must place their initial next to the specific type(s) of information to be disclosed.*

_____ Office Records _____ Dates of Service _____
_____ X-ray Reports _____ Dates of Service _____
_____ Laboratory Tests _____ Dates of Service _____
_____ Immunization Records _____ Dates of Service _____
_____ Information regarding _____
_____ Other - Describe records required and give approximate date(s) of service:

3. This authorization can be revoked, in writing, at any time except to the extent that information has already been released or
disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for the
release has been achieved. We will not condition treatment or payment based upon this Authorization or Revocation of Autho-
rization unless otherwise allowed by law.

4. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days
after the date below, whichever is later.

Signature of Patient _____ Date _____

Birth Date of Patient _____ Social Security Number of Patient _____

Consent of legal guardian, patient advocate or personal representative if patient is incapable or is a minor.

Signature of guardian, patient advocate,
or personal representative _____ Date _____

Relationship _____

Address _____

Phone Number _____ Witness _____