AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize release of health information for the individual named below.

Patient Name **Date of Birth**

PICK ONE OF THE FOLLOWING:

_________ I authorize Apple Family Medicine, P.L.C. to release information to the organization named below.

_________ I authorize the organization named below to release information to:
Apple Family Medicine, P.L.C. 1042 S. Ravenna Rd. Ravenna, MI 49451
Telephone (231) 853-2519 Fax (231) 853-2838

Name of Doctor or Facility **Telephone Number**

____ ________________________

Address **Fax Number**

____ ________________________

Treatment Dates

____

Reason for Transfer ________________________

____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this limited authorization in writing at any time at the address on the top of this form, except to the extent that action has been taken in reliance on this authorization. This authorization is in effect until revoked by me or until it expires, as noted below.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

____

Redisclosure: If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulation, I understand the information described above may be redisclosed and no longer protected by these regulations.

Other Rights: I understand I may refuse to sign this authorization and that my refusal will not affect the use or disclosure of my protected health information for purposes of treatment, payment, or healthcare operations. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I may inspect or copy any information used/disclosed under this authorization.

_____________________________________ ______________________
Signature of Patient or Legal Representative Date

____________________________________ ______________________
Witness Date