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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THE PRACTICE

_____ _____
Print Patient's Name Date of Birth

1. By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me to **_____.**

2. The information to be used or disclosed is as follows: (specifically describe the information to be used or disclosed, such as date(s) of services, lab work, pathology report, type of services, level of detail to be released, origin of information, etc.):

_____
_____

3. The information will be used or disclosed for the following purpose:

☐ Continuity of Care ☐ "At the request of the individual"

☐ Other _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

4. This authorization will expire on _____
{Expiration Date or Defined Event}

5. I understand that I do not have to sign this authorization in order to receive treatment from Patrick A. Wegman, M.D.

6. I have the right to refuse to sign this authorization.

7. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

8. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Patrick A. Wegman, II, Practice Manager
802 W. King Suite H
Owosso, Michigan 48867

Signed by:_____ _____
Signature of Patient, Parent, or Legal Guardian Today's Date

_____ _____
Print Name of Parent or Legal Guardian Relationship to Patient