



**7.31 Patient Authorization for Disclosure of Protected Health Information**

Please print all information, then sign and date form at bottom.

**Type of Authorization:** Release of protected health information to a designated person.

**Patient Name** (please print) \_\_\_\_\_

**Purpose of request** - I authorize Mid-Michigan Physicians, P.C. to disclose or provide protected health information, about me, to (please identify person or persons who will receive the information):  
\_\_\_\_\_

**Description of information to be disclosed** - I authorize Mid-Michigan Physicians, P.C. to disclose the following protected health information about me to the person identified above (please provide a written description of the information to be disclosed):  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose of disclosure** – (please list the purpose of the disclosure):  
\_\_\_\_\_  
\_\_\_\_\_

**Expirations or termination of authorization** – This authorization will expire at the end of the calendar year in which the authorization was initiated, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): \_\_\_\_\_

**Right to revoke or terminate** – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

**Mid-Michigan Physicians, P.C.**  
**Attn: Privacy Manager**  
**2510 Kerry St.; Suite 200**  
**Lansing, MI 48912**

**Redisclosure** – 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 will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of our practice.

\_\_\_\_\_  
patient signature

\_\_\_\_\_  
date