

This form is intended to serve as a sample for Michigan attorneys assisting clients with forms for HIPAA compliance. Under HIPAA preemption standards a HIPAA form is not intended to replace a current form being used in compliance with applicable Michigan law. Use of the sample HIPAA forms will require integration of the HIPAA sample form with existing forms currently in use. The attorney also may wish to consult the HIPAA Matrix to determine if any preemption issue under Michigan law needs to be addressed in the form. This form is for educational purposes only and does not constitute, and may not be relied upon, as legal advice.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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I, _____, authorize the following person or entity:

Name: _____ Address: _____

City/State/Zip: _____ to disclose protected health information (PHI) of:

Name: _____ (“Patient”) Address: _____

City/State/Zip: _____ Telephone #: _____

Social Security #: _____ Health Record #: _____

Disclosure is to be made to: Name _____

Address: _____ City/State/Zip: _____

I understand that this authorization allows disclosure and use of PHI of Patient which is protected under federal and state law, including records regarding alcohol and drug treatment, social work counseling, mental health care, venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and other personal and medical information.

I understand that this authorization will be considered to be made at Patient’s request unless I specify a specific purpose for the authorization as follows: _____

I understand that all of Patient’s PHI will be disclosed unless I specify a limitation as follows: _____

This authorization will expire 1 year from the date I sign it, unless I specify that it expires after the following date or event: _____

I understand I may revoke this authorization at any time. However, any revocation must be in writing directed to the Privacy Officer of the disclosing entity and a revocation will not affect any actions taken before the revocation is received.

I understand that authorizing the disclosure of PHI is voluntary and that I can refuse to sign this authorization.

I understand that this disclosure of PHI is protected by law, but that any disclosure of PHI carries the potential for re-disclosure where the information would no longer be protected by law.

I understand that the person or entity I authorize to disclose PHI by this authorization may not condition Patient’s care, treatment, payment, enrollment in a health plan or eligibility for benefits on providing this authorization.

Patient signature: _____ Date: _____

If signer other than Patient: _____ Relationship to Patient: _____