

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.

General Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with state and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize the use or disclosure of my health information as follows:

Name of individual: _____ Date: _____

Address: _____

Telephone: _____ Social Security #: _____ Date of birth: _____
(Optional)

Persons/Department/Organizations at the _____ (name of MO) authorized to *use or disclose* the information:

_____.

Persons/Organizations at the _____ authorized to *receive* the information:

_____.

My health information will be used for the following purpose(s) (ex: Marketing Activities, Fundraising Activities, employment determination, etc.) (To be completed by Requestor or Individual)

(You do not have to state a reason a sufficient purpose may be to state "patient request".)

This Authorization applies to the following information (select *only one* of the following):

The following records or types of health information (including any dates): _____

All health information pertaining to any medical history, mental or physical condition and treatment received. [Optional] Except: _____

All billing information pertaining to the following dates of service or all dates of service on or after _____

EXPIRATION:

This Authorization expires [insert date or event]: _____

YOUR RIGHTS:

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this Authorization. (NOTE: Inspection and copying is not required if the disclosure is made directly to the patient.)

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

I understand that I may revoke this limited Authorization in writing at any time at the address found below, 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 under applicable laws.

- If this box is checked, the Requestor will receive payment for the use or disclosure of my information. [*Only applicable if the Organization will receive remuneration*]. I understand that the Organization will receive payment, either directly or indirectly as a result of uses and disclosures of my protected health information that I have authorized by signing this Authorization.

Signature of Patient or Representative

Date

Relationship to the patient

Signature of Workforce Member (Witness)

Date