

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.

**SAMPLE AUTHORIZATION FOR HOSPITAL'S LIMITED
USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I authorize the use/disclosure of protected health information (**PHI**) about me as described below.

1. Person(s) or class of persons authorized to use/disclose the information:

2. Person(s) or class of persons authorized to receive the information:

3. Description of information that may be used/disclosed:

4. The information will be used/disclosed for the following purposes: (NOTE: **The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.**)

5. **Please provide an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.**

5. 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.

6. I understand that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations.
(NOTE: This item is not required if the disclosure is made directly to the patient.)
7. 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.

Signature of Patient or Representative

Date

Patient's Name

If the authorization is signed by a personal representative, a description of the representative's authority to act for the individual must be provided:

Name of Personal Representative (if applicable)

Relationship to Patient

(A copy of this signed form will be provided to the patient)

Hospital Name and Address

