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**AUTHORIZATION FOR THE USE OR DISCLOSURE OF MY HEALTH INFORMATION**

By signing below, I hereby authorize my protected health information to be used or disclosed for my treatment and diagnoses, and for the specific purpose of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. \**If the use or disclosure is at the patient’s request, insert “At the Patient’s Request” instead of a specific purpose.*

**My Protected Health Information may be disclosed to my:**

|  |  |  |
| --- | --- | --- |
| Physicians: | YES | NO |
| Pharmacists: | YES | NO |
| Health Care Providers: | YES | NO |

**This facility may disclose my Protected Health Information to the following persons:**

|  |  |  |
| --- | --- | --- |
| Spouse | YES | NO |
| Family Members | YES | NO |

Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I use an answering machine at home, this facility is authorized to leave messages on it, regarding protected health information. Yes No

I understand that I have the right to revoke this Authorization, if the revocation is in writing except if:

* This office has taken action in reliance upon this Authorization; or
* This Authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to contest a claim made under the insurance policy.

I understand that this authorization will remain in effect until such times as I revoked it by delivering written notice to:

**Rochester Medical Center**

**P.O. Box 82177**

**Rochester, MI 48308**

**Attn: Custodian of Vital Records**

I understand that my Protected Health Information that is used for disclosure pursuant to this Authorization may be subject to redisclosure by the person(s) you have disclosed it to, and the privacy of my Protected Health Information will no longer be protected.



I acknowledge that I have read and understand this Authorization. I authorize the use of Disclosure of my Protected Health Information in accordance with the terms of this Authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature Patient’s name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed by Patient Witness