MMP
MID-MICHIGAN PHYSICIANS, P.C.

7.32 Patient Authorization for Disclosure to Designated Provider

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

Purpose of request - I request and authorize the disclosure or release of my protected health information (as identified below) to the following provider:

Entity Requesting Information:
The patient information is being requested by:

Practice:_____

Provider: _____

Address:_____

City, State, Zip:_____

Phone:_____

Fax:_____

Entity Providing Information:

Practice:_____

Provider:_____

Address:_____

City, State, Zip:_____

Phone: _____

Fax: _____

Patient Information - The requested information is for the following patient:

_____ _____ _____
Patient Name Date of Birth Social Security Number

_____
Address

_____
City, State, Zip

Description of information to be disclosed - I authorize the disclosure of the following protected health information about me to the provider identified above (check one of the following):

___ Complete medical record; or ___ the following limited information (provide description):

_____

_____

Purpose of disclosure: (please list the purpose of the disclosure **OR** check patient request):

☐ **patient request**

_____

_____

- **Expirations or termination of authorization:** This authorization will expire within 14 days from the date of my signature below.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization.
- **Rediscloure:** 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 this practice.

_____ _____
patient signature date