Limited Patient Authorization for Disclosure of Protected Health Information (PHI)

(Please print all information. Form must be signed and date)

Patient Name: ______________________________

SSN (last four digits): ______________ Date of Birth: ______________

Purpose of request (who will be authorized to receive information) - I authorize the practice to disclose or provide protected health information, about me to the individual(s) listed below.

Who will provide or disclose information: Glaucoma Center of Michigan
29201 Telegraph Rd., Suite 301
Southfield MI 48034

Who will be authorized to receive information (list each family member, friend, or other individual to receive PHI):

____
Name of Personal Representative Phone Relation

____
Name of Personal Representative Phone Relation

____
Name of Personal Representative Phone Relation

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: ______________________________

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request o Other (please specify): ______________________________

Expirations or termination of authorization: This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. (Please list the date of expiration if earlier than the end of the calendar year)

Right to revoke or terminate: You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

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 may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

______________________________ ______________
Patient signature Date

You have the right to receive a copy of signed authorizations upon request.