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AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

To: **Michigan Primary Care Partners, PC d/b/a Medical Specialists**

__________________________ **Patient Last**

__________________________ **Patient First**

______/_______/_________ **Date**

____ **Patient Signature**

____ **Patient Representative Signature**

____________________________ **Patient Representative Relationship**

Persons/organizations to whom PHI may be disclosed:

____

____

Information to be disclosed or used:

____

____

Purpose of disclosure:

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____

This authorization is effective through ______/______/__________ unless revoked or terminated earlier by the patient or the patient's representative. You may revoke this authorization by submitting a written revocation letter to **Michigan Primary Care Partners, PC d/b/a Medical Specialists**.

POTENTIAL FOR RE-DISCLOSURE: Information that is disclosed under this authorization may be disclosed again by the person/organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once we disclose it to another party.

EFFECT OF REFUSING AUTHORIZATION: If you refuse to sign this authorization, we will not deny you any treatment.

Form #537.12.22.10