

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION
Pursuant to 45 CFR 164.508

1. I, (NAME IN CAPITAL LETTERS), authorize the use of disclosure of the following individual(s) health information as described below:

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Health Records Number: _____

2. The following organization, individual or department of the organization is authorized to make the disclosure:

Name: _____

Address: _____

Telephone Number: _____

3. The type and amount of information to be used or disclosed is as follows:

_____ complete and full record
_____ billing records
_____ x-ray and imaging reports from (date) _____ to (date) _____
_____ admission and discharge summaries
_____ pertinent packages of records
_____ office records
_____ other _____

4. I understand that the information in the Patient(s) health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services and treatment for alcohol and drug abuse.

5. This information may be disclosed to the following organization, JOHN J. CONWAY, P.C. or its representative, which is located at 645 Griswold Street, Suite 3600, Detroit, MI 48226.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health informational management department of the Custodian listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to the Patient(s) insurance company when the law provides the Patient(s) insurer with the right to contest a claim under the Patient(s) policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient (or Legal Representative)

Date

If Signed by Legal Representative, Relationship to Patient

Subscribed and sworn to before me this
____ day of _____, 2006

Notary Public
_____, County,
My commission expires: _____