

Authorization for Release of Medical Information

I, _____, with a social security number of _____

authorize _____ to release the following medical information to

(Please initial appropriate box):

_____ Any and all of my medical record (as of the date of this release);

_____ Any and all of my medical record except the following:

This release also specifically allows the release of the following information (this information will not be released unless the appropriate box is initialed):

___ Any record of treatment for Drug and/or Alcohol dependency or abuse;

___ Any record of Mental Health treatment;

___ Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This information is being released for the following purpose(s) only: _____

_____ and may not be used

for any other purpose or released to any other person(s) without my written consent.

This release is effective for six months from the date of execution, however, it may be revoked by me at any time by providing notice in writing to the above named party.

Signature: _____ Date: _____

Patient/Legal Guardian of Patient

HIPAA Privacy Information:

By signing this Authorization, I hereby give my consent for Michigan Brain & Spine to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (Michigan Brain & Spine's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Michigan Brain & Spine reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained by forwarding a

written request to the Michigan Brain & Spine Privacy Officer at 5315 Elliott Dr., Ste 102, Ypsilanti, MI 48197. **Fax this form to Michigan Brain & Spine at 734-434-1966.**