

# DELTON MEDICAL CENTER

11320 S. M-43 Hwy, P.O. Box 675, Delton, MI 49046

Phone #: 269-623-5521 Fax #: 269-623-5527

## AUTHORIZATION FOR ACCESS TO PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_, hereby authorize Delton Medical Center, to use or disclose the following protected health information: *(specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)*

Scheduling Information

Financial Information

Lab Reports

Radiology Results

Office Visit Information

Other: \_\_\_\_\_

The protected health information may be disclosed to *(Name(s) of person(s) who are authorized to have access):*

Name: \_\_\_\_\_ Last 4 #'s of SSN: \_\_\_\_\_

Name: \_\_\_\_\_ Last 4 #'s of SSN: \_\_\_\_\_

This protected health information is being used or disclosed for the following purposes: *(List specific purposes, the patient may indicate that the information to be disclosed is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request).*

\_\_\_\_\_  
\_\_\_\_\_

This authorization shall be in force and effect until: *(Check one)*

Date: \_\_\_\_\_

The happening of the following expiration event: \_\_\_\_\_

I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification.

I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

By signing this authorization, I have acknowledged that I have read and understand this authorization and I authorize the use and disclosure of my protected health information in accordance with the terms of this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority