AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

____________________________________	__________________________________
Name of Patient	Birth Date and/or Social Security No.
____________________________________	__________________________________
Street Address	City, State, Zip Code
I hereby authorize:	**To disclose my protected health Information, as described below, to:**
Michigan-Wisconsin Family Practice Assoc., P.C.	____________________________________
Name of individual or Entity	Name of individual or Entity
1711 S. Stephenson Ave., Suite 300_____________	____________________________________
Street Address	Street Address
Iron Mountain, MI 49801____________________	____________________________________
City, State, Zip Code	City, State, Zip Code

Information to be released:

_______Entire medical record including information related to HIV.

_______Entire medical record excluding information related to HIV.

Other ____

Purpose for Need for Disclosure:

_______Medical Care	_______Personal Information
_______Insurance	_______Other________________________

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to revoke this authorization, except to the extent that the person(s) and or organization listed above have already made in reference to this authorization.

If deemed necessary, I authorize this information to be sent via facsimile (fax) transmission.

The physician, facility, and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

This authorization shall be effective following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the above listed physician and/or facility. A photocopy of this authorization shall constitute a valid authorization.

____	____
Signature of Patient (or Legal Representative)	Date

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Relationship to Patient (if applicable)