Michigan-Wisconsin Family Practice Associates, P.C.
Daniel M. Mitchell, M.D.
Beth A. Schroeder, M.D.
Phone (906)774-1633
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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:

_____ Name of individual or Entity

_____ Street Address

_____ City, State, Zip Code

To disclose my protected health Information, as described below, to:

(Please circle one)

Daniel M. Mitchell, M.D. or Beth A. Schroeder, M.D.
Name of individual or Entity

1711 S. Stephenson Ave., Suite 300
Street Address

Iron Mountain, MI 49801
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

_____Insurance

_____Personal Information

_____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

_____ Relationship to Patient (if applicable)