AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Billing Information: _____

Phone Number: ( ) _____

I, _____ here by authorize,
(Patient's Name)

Physician's Name/Office _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Its Director or Designee, or Health Information Management/Medical Records Department, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2. If any; behavioral medicine services record, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131. if any, which includes venereal diseases, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below.

1. Name of person(s) or organizations(s), to whom disclosure is to be made:

Family First Health Care Yale-Lexington

7470 Brockway Rd
Yale, MI 48097
Phone: (810) 387-9355
Fax: (810) 387-9400

5730 Main Street
Lexington, MI 48450
Phone: (810) 696-2088
Fax: (810) 696-2094

NOTE: IF OVER 50 PAGES PLEASE MAIL DO NOT FAX (UNLESS OTHERWISE NOTED)

2. Specify type of information to be disclosed: **Any/All**
3. Reason for disclosure: **Continuation of Care**
4. This authorization can be revoked, in writing, at any time except to the extent that the information has already been released or disclosed. Any authorization for the release of disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved.
5. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date below, whichever is later.

Signature: _____ Date: _____
(Parent or Responsible Party)

Witness: _____ Date: _____