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Authorization for Use or Disclosure of Medical Information

I,____ whose date of birth is_________________
authorize Family Practice of Cadillac, P.C. to

send medical records to:	receive medical records from:
___________________________________	____________________________________
___________________________________	____________________________________
___________________________________	____________________________________

Please check one of the following:

❑ Any and all of my medical records (a two year history will be provided unless otherwise specified)

____

❑ The following records only:____

____

If you wish to have the following released, please check the appropriate box. (Information NOT checked WILL NOT be released.)

❑ Treatment for drug and/or alcohol dependency or abuse.
❑ Treatment of mental health.
❑ Testing, care, treatment, reporting, or research pertaining to HIV or related diseases.

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

____

This release is effective for six months from the date of execution. 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 to the Privacy Officer at the address above. I understand that 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.

____ __________________
Signature of Patient or Personal Representative Date

____
Personal Representative's Authority

07-26-2006