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Authorization for Disclosure of Medical Information

I,____ whose date of birth is_________________ authorize Family Practice of Cadillac, P.C. to release protected health information to the following person(s):

List individual(s) who authorization is granted to: (please limit access to two individuals)

1. Name____

   Relationship____________________________ Home (or Cell) Phone___________________

2. Name____

   Relationship____________________________ Home (or Cell) Phone___________________

Addition Comments/Requests____

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This release is effective until revoked. 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