

**Family Practice of Cadillac, P.C.**  
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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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Personal Representative

\_\_\_\_\_  
Relationship