Patient HIPAA Authorization For Physician To Release To And Discuss With Attorney Any And All Protected Medical Information

Physician: _____

Address: _____

_____

I, _____

residing at _____

with Social Security Number _____,

and Date of Birth _____ authorize the above-named physician and/ or medical

facility to release to and discuss with attorney _____ any and all protected medical information as defined under the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the Medical Records Access Act as is necessary, and covers all protected information from primary and secondary providers, health plans, health care clearinghouses, emergency services, financial and administrative transactions, and business associates.

I authorize the above-named physician and/ or medical facility to release and discuss any and all including but not limited to, my medical history, my medical treatment, your findings regarding my medical condition, records of consultations that I have had, records of medication prescribed for me, x-rays taken of me, my radiology reports, and hospital, medical, and billing records.

This Authorization is intended to be a limited authorization for the release of any and all protected medical information as defined under the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the Medical Records Access Act, as amended, and under the rules and regulations thereof, as is necessary to confirm the validity of my certification, and covers all protected information from primary and secondary providers, health plans, health care clearinghouses, emergency services, financial and administrative transactions, and business associates. A covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b)(4) applies. It is understood that the person to whom this Authorization is given has my permission to use and disseminate this information in his or her sole discretion.

1. **Expiration.** This Authorization expires 18 months after the date this Authorization was signed by Patient.

2. **Right to Revoke.** I have the right to revoke this Authorization by signing and dating a written statement revoking this Authorization, and it shall become effective on delivery to you. If this Authorization is revoked, any person or entity acting in good faith in reliance upon it and lacking actual knowledge of its revocation shall be held harmless.

3. **Re-disclosure.** Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected by this rule.

4. **Administrative Provisions.** I revoke any prior authorizations I have made to disclose health information that are inconsistent with this Authorization. This document shall be governed by Michigan law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub L No 104-191, as amended, and the Medical Records Access Act, MCL 333.26261 et seq. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to Michigan law and HIPAA to interpret and determine the validity and enforceability of this document. Photocopies or facsimile reproductions of this signed Authorization shall be treated as original counterparts.

I am providing this Authorization voluntarily and have not been required to give it to obtain treatment. I am at least 18 years old and of sound mind.

Dates of Service: _____

Patient's Signature: _____ **Date:** _____

Printed Patient name: _____