LIGHTHOUSE
FAMILY MEDICINE

Authorization to Disclose Health Information

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____PHONE: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below
2. The following organization is authorized to make the disclosure: **Lighthouse Family Medicine**
3. The type and amount of information to be used or disclosed is as follows:

□ **Entire record**
□ Problem list
□ Most recent encounter
□ Most recent history & physical
□ Dates: from _____ to _____
□ Laboratory results
□ X-ray and imaging reports
□ Medication list
□ Immunization record

4. I understand the information in my health record may include information relating to sexually transmitted infections, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Name _____

Address _____

6. I understand that I have the right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy office of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in 6 months from the date of authorization.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment by my healthcare providers. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal or state privacy rules. If I have questions regarding the disclosure of my health information by this practice, I can contact the privacy officer.

_____ _____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient

Before 8/31/2023
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Fort Gratiot, MI 48059

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After 8/31/2023
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