

HIPAA Compliant Authorization for Release of Patient Information Pursuant to 45 CFR 164.508

SECTION I – Patient Information :

Name:		Social Security Number:
Street Address:		Birth Date:
City:	State:	Zip Code:
Telephone:	Email:	

I, or my authorized representative, hereby authorize MidMichigan Therapeutic Massage Care, LLC (hereinafter referred to as "MMTMC") and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to the designee identified below.

SECTION II –Authorized Designee (to whom the information will be disclosed):

Name:		Relationship:
Street Address:		Telephone:
City:	State:	Zip Code:

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION** only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person (authorized designee) indicated in Section II.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to MMTMC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, or eligibility for other MMTMC massage services or benefits will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient, and the redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN SECTION II.**

SECTION III – Specific Information to be Released:

<input type="checkbox"/> Please release my Medical Record from (insert date) _____ to (insert date) _____	
<input type="checkbox"/> Please release my entire Medical Record, including patient histories, SOAP notes, office notes (excluding psychotherapy notes, test results, radiology studies, films, referrals, consults, billing records, insurance records sent to MMTMC by health care providers).	
<input type="checkbox"/> Other: (please explain) _____	<input type="checkbox"/> Include: (Indicate by Initialing)
_____	_____ Alcohol/Drug Treatment
_____	_____ Mental Health Information
_____	_____ HIV-Related Information

SECTION IV – Reason for release of information (A description of each purpose of the requested use or disclosure):

At the request of the individual

Other: _____

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:

Date or event on which this authorization will expire: _____

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE:

Name:		Relationship:
Street Address:		Telephone:
City:	State:	Zip Code:

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

Signature of Patient/Client or Authorized Representative

Date