MidMichigan Health
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

Designation of Release Of Health Information

MidMichigan Physicians Group

All MidMichigan Health affiliated provider offices adhere to a policy of not releasing protected health information to individuals other than the patient. By indicating below, **you can designate others to receive your health information.**

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

Choose Option A or Option B listed below:

Option A	Option B
☐ I choose to have my health information released only to me.	☐ I authorize any and all doctors and providers employed by a MidMichigan Health affiliate to release protected health care information about myself to the following individual(s): ☐ I authorize ______________________ (s) office to release protected health care information about myself to the following individual(s): ______________________ Name ______________________ Relationship ______________________ Name ______________________ Relationship ☐ Any/All Information: ______________________ ☐ Specific Information: ______________________

By indicating below, **you may also elect to receive messages with more detailed information than the standard allows.**

I authorize MidMichigan Health to leave detailed messages relating to my medical information on my answering machine at:

________ Pt. Initial	☐ Home	Phone Number: ______________________
________ Pt. Initial	☐ Work	Phone Number: ______________________

I hereby grant the above elected methods of communicating my protected health information. Furthermore, I understand that I may at any time change or rescind my elections either by completing a new form, or by written correspondence with this office; otherwise, this election is valid for 12 months.

______________________ Patient/Parent/Legal Guardian Signature ______________ Effective Date

______________________ Witness Signature ______________ Date

Patient Name: ______________________ D.O.B: ______________ Chart #: ______________