Little Traverse Bay Bands Health Department

RELEASE OF PROTECTED HEALTH INFORMATION (additional authorizations)

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or health care operations, or other disclosures. I also have the right to authorize the release of my protected health information to members of my family, friends and/or any person that is involved in my care.

I authorize the following person/persons to obtain my health information:

_____

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

(If Legal Representative, state relationship to patient)

_____

Witness

☐ Accepted ☐ Denied

_____

(This authorization will be null and void after this date)

Name Record #

Address City/State/Zip

Date of Birth