LITTLE TRAVERSE BAY BANDS HEALTH DEPARTMENT

RELEASE OF PROTECTED HEALTH INFORMATION

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(s) to obtain my health information:

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SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE
(IF LEGAL REPRESENTATIVE, STATE RELATIONSHIP TO PATIENT)

______________________ ______________________
DATE EXPIRATION DATE OF AUTHORIZATION

____
WITNESS NAME & SIGNATURE

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CLINIC USE ONLY – DO NOT WRITE BELOW THIS LINE

DATE RECEIVED:______________________
CLINIC INTAKE INITIALS:______________

LTBB HEALTH RECORD NUMBER (HRN)__________