AUTHORIZATION FOR EXCHANGE OF PATIENT INFORMATION

YOU give permission, to the person listed below to access medical history and ability to contact us on your behalf.
For example: spouse, family member or friend

IMPORTANT: All blanks **MUST** be filled in

Patient Name:	Birthdate:
Address:	Phone:
City/State	Zip code:

I authorize Little Traverse Primary Care to exchange information with:

Name	Birthdate:
Address:	Phone:
	Relationship to Patient:

Indicated by my initials below, this authorization may include disclosure of specific information relating to:

(I understand that I am not required to initial the specific information below. I may revoke this authorization at any time by sending a written notification to the privacy officer.)

_____ Communicable disease and infection information as defined by statue and Michigan Department of Public Health Rules.
_____ Alcohol and/or Drug abuse treatment protected under regulation in 42 Code of Federal Regulations, Part 2.

_____Mental health, psychological treatment records and social services information, including communication made by me to a social worker or psychologist.

____ Birth Control Treatment

TIME PERIOD: (Circle one) ***INDEFINITE*** ***1 YEAR*** ***SPECIFIC TIME PERIOD***: _____

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.
I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

- If the patient is 18 years of age or older, the patient must sign and date form
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  - ☐ Legal Guardian/Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- The patient is under 18 and I am the **parent** or **legal guardian** (circle one) signing and dating this form.

_____ _____
Patient/Guardian/Legal Representative Signature Date

_____
Printed name of signer **IF NOT PATIENT**