MACOMB MEDICAL CLINIC, P.C.

Patient Authorization for use and disclosure of Protected Health Information

HIPAA AUTHORIZATION FORM

I, ______________________________________ Date of Birth: _____/_____/________ authorize Macomb Medical Clinic, P.C. Physicians and/or staff to discuss the information contained in my medical record and/or provide copies of my Protected Health Information to the following persons:

☐ Spouse ____

☐ Children ____

☐ Other ____

"In the course of providing care, MACOMB MEDICAL CLINIC, P.C. providers will share either written or electronic patient information with other providers who are involved in the patient's car, as appropriate."

By signing, I authorize MACOMB MEDICAL CLINIC, P.C. to use and/or disclose certain ***Protected Health Information*** **(PHI)** about me to carry out ***Treatment, Payment and Health Care Operations*** **(TPO)**. The Notice of Privacy Practices provided by MMC describes such uses and disclosures more completely.

With this consent, MACOMB MEDICAL CLINIC, P.C. may call my: (***Please Circle One***) HOME CELL or WORK and leave a message on a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as letters to include, but not limited to; reminders, abnormal results, statements, the need to return to the clinic for an office visit, insurance items and anything pertaining to my clinical care.

With this consent, MACOMB MEDICAL CLINIC, P.C. may mail to my home or alternative location, any items that assist the practice in carrying out TPO, such as, but not limited to; reminder cards, abnormal cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, MACOMB MEDICAL CLINIC, P.C. may email me to the address I have provided, any items that assist the practice in carrying out my TPO such as reminder cards, abnormal cards, and patient statements. I have the right to request that MACOMB MEDICAL CLINIC, P.C. restrict how it uses or discloses my PHI to carry out my TPO. The Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

The purpose(s) is/are provided to that I could make an informed decision whether to allow the release of the information. I may revoke my consent at any time in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. This authorization is effective as of the date signed and **expires two (2) years from that date or, if checked HERE ☐ it is considered indefinite.**

It is understood that, in the event of my demise, my PHI will only be released to the individual who is recognized by the Court as my Personal Representative or by a property executed order from a Court.

I do not have to sign this authorization in order to receive treatment from MACOMB MEDICAL CLINIC, P.C. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed in accordance to this authorization, it may be subject to re disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

I HAVE ACCESS TO THE FULL NPP HIPAA RULES IN THE OFFICE LOBBY AND UNDERSTAND THAT I HAVE THE RIGHT TO VIEW THEM PRIOR TO SIGNING THIS FORM. AGREE DISAGREE

__________ Please Initial __________ Please Initial

X____ __________________

Signature of Patient or Personal Representative Date

If Personal Representative: ____ ____________________

(Please print your name) Relationship to Patient

*******I HAVE BEEN OFFERED A COPY OF THIS NOTICE AT THE TIME OF THIS SIGNING*******_______________

Please Initial

English Version:

Macomb Medical Clinic, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Spanish Version:

Macomb Medical Clinic, P.C. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.