West Michigan Surgical Specialists PLC

HIPAA AUTHORIZATION

In compliance with the Privacy Practices of West Michigan Surgical Specialists PLC this form will allow you to designate an individual(s) to whom West Michigan Surgical Specialists may disclose your protected health information.

This may include individually identifiable information related to past, present or future appointments, and medical or financial information. This does not include information relating to mental health treatment or HIV test results as releasing that information requires your separate written consent.

Patient Name ____ Date of Birth _________________

Phone Number ____

I DO HEREBY AUTHORIZE WEST MICHIGAN SURGICAL SPECIALISTS TO DISCLOSE PROTECTED HEALTH INFORMATION TO THE FOLLOWING:

Name	Relationship to Patient	Telephone Number
________________________	________________	________________
Name	Relationship to Patient	Telephone Number
________________________	________________	________________
Name	Relationship to Patient	Telephone Number
________________________	________________	________________
Name	Relationship to Patient	Telephone Number

By signing below, I acknowledge that I have had opportunity to read the content of this authorization and understand that my protected health information may be disclosed to the individual(s) listed above. I understand that designating the individual(s) listed above does not exclude West Michigan Surgical Specialists from disclosing my protected health information as outlined by WMSS Privacy Practices

I understand that I have the option to revoke this authorization at any time, at which time I can execute a new authorization. I also understand that unless revoked in writing by completing a new authorization form, this authorization will remain in effect until I choose to revoke it.

____ ________________________

Patient Signature Date

____ ________________________

Personal Representative (Relationship to Patient) Date