

**AUTHORIZATION FOR ACCESS TO PROTECTED HEALTH INFORMATION**

Name of individual: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize disclosure of my protected health information, including information about my health and treatment to the individual(s) listed below. I further request that the person(s) listed below is able to make requests on my behalf and be considered by personal representative:

1. List the name of the person(s) who are authorized to have this access:

\_\_\_\_\_

2. This authorization shall expire on the following date or event (e.g. none)

\_\_\_\_\_

3. I understand that I have the right to revoke this authorization in writing and acknowledge that Asthma Allergy Centers of SW Michigan is not responsible for subsequent uses or disclosures made to me or others that I have authorized to have access to my record.
4. By signing this authorization, I acknowledge that I have read and understand this authorization and I authorize the use and disclosure of my protected health information in accordance with the terms of this authorization.

\_\_\_\_\_  
Signature or patient

\_\_\_\_\_  
date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
date

**Procedure for Revocation of an authorization:**

**Upon request, our practice will provide a Revocation of Authorization Form to any individual seeking to revoke a previously signed Authorization Form. Upon receipt of a signed and dated Revocation of Authorization Form, we will terminate all uses and disclosure of the Individual's Protected Health Information covered by the specific authorization that is revoked. The revocation will be effective on the date that the signed Form is received or the date specified on the Form, whichever is later, except that to the extent that exceptions should be noted.**