

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release

healthcare information of the patient named above to:



Name: **Members Private Healthcare, PLLC**

Address: **31330 Northwestern Hwy, Ste D**

City: **Farmington Hills** State: **MI** Zip Code: **48334**

Phone: **248-918-2337** Fax: **248-579-2406**

This request and authorization apply to:

- Healthcare information relating to the following treatment, condition, or dates:
- All healthcare information
- Other:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes \_\_\_ No \_\_\_ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes \_\_\_ No \_\_\_ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED**

## CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

### PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

- Phone Message    Text Message    Email    **Any of the above**    None of the above

**\*In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.**

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### Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign because \_\_\_\_\_
- Other (please describe) \_\_\_\_\_

Signature of the Privacy Officer \_\_\_\_\_ DATE Signed \_\_\_\_\_



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E: admin@membersprivatehealthcare.com