



Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated.

Patient Name: _____ Date of Birth: _____

Purpose of request (who will be authorized to receive information): I authorize **WEST MICHIGAN DERMATOLOGY** to disclose or provide protected health information, about me to the individual(s)/entities listed below.

Name: _____ Relationship: _____ Phone: _____

- Entire Patient Record; or check only those items of the record to be disclosed.
- Office Notes
- Nursing Home, Home Health, Hospice, & Other Physician Records
- X-Rays, Lab Results, Pathology Reports
- Record of HIV and Communicable Disease Testing
- Financial History (previous 3 years only)
- Record of Mental Health or Substance Abuse Treatment
- Emergency Contact

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*Secure Communication – Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate fax or email as your preferred method of disclosure if this is of concern to you.

- This authorization will expire 3 years from the date signed unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of the expiration if earlier than the end of the 3rd year.
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient or authorized representative signature

Date

PRINTED NAME of patient or authorized representative

GRANDVILLE

3434 RIVERTOWN POINT CT. SW
GRANDVILLE, MI 49418
[P] 616.257.3344 [F] 616.257.1491

HOLLAND

3290 N. WELLNESS DRIVE, BLDG. D., SUITE 240
HOLLAND, MI 49424
[P] 616.395.9379 [F] 616.820.1457

GRAND RAPIDS

750 EAST BELTLINE AVE. NE, SUITE 301
GRAND RAPIDS, MI 49525
[P] 616.942.9343 [F] 616.942.2538