Saint Clair Allergy and Asthma Center, PLLC

25200 Little Mack Ave. Saint Clair Shores, MI 48081

HIPAA Authorization Form for Family Member/Friends

I, _____, give my permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health Information to be Disclosed (Check all that apply):

- ○ My complete heath record (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ○ My complete health record, as above, with the exception of the following information:
  - ○ Mental health records
  - ○ Communicable diseases (including HIV and AIDS)
  - ○ Alcohol/drug abuse treatment
  - ○ Other (please specify) _____

    _____

This authorization shall be effective until (Check one):

- ○ All past, present, and future periods, OR
- ○ Date or event:_____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization | Date of Birth

_____ _____

Signature of the Individual Giving this Authorization | Date