# Authorization to Use or Disclose Protected Health Information

This authorization will permit DME Medical Supply Specialists the ability to use or disclose an individual's protected health information (PHI). Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

I, ___________________________________________ (Full Name of Patient) give DME Medical Supply Specialists, whose address and contact information is at the bottom of this form, the right to disclose my protected health information for the purposes I have noted. I understand by completing and signing this form I agree and acknowledge as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment or eligibility for services or products (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:
Month: ________ Day: ________ Year: _________.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to DME Medical Supply Specialists. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** if it is noted in the records from other health providers. I understand that the only information that will not be disclosed will be what I have noted below under "Information I do not want disclosed". If no information is indicated in that area then by signing this form you are giving permission to release all information.

Information regarding patient for whom authorization is made:

Full Name: ______________________________________________________________________

Other Name(s) Used: ______________________________ Date of Birth: ___________________________

Address:________________________ City: __________________ State: _________ Zip Code: _______

Phone: (___)________________________ Email (*optional)*: ______________________________________

Information regarding person or entity to receive and use this information:

Name: _________________________________________________________________________

Address: _____________________________ City: ________________ State _______ Zip Code: ________

Phone: (___)__________________________ Fax: (___)__________________________________________

DME Medical Supply Specialist
DBA of Dare Consulting Group LLC
(248) 282-4900 Office

31100 Telegraph Rd., Suite 150
Bingham Farms, MI 48025
(248) 498-5960 Fax

Specific Information to be disclosed:

Any or all medical record that DME Medical Supply Specialists has which may or may not include: patient histories, office notes, test results, radiology studies, billing records, insurance records, and records received from other health care providers.

Other information you wish disclosed:_______________________________________________________

Information I do not want disclosed: ________________________________________________________

Reason for release of information: (Choose any that Apply):

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other: ________________________________________________________

**Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURES:**

Patient/Legal Representative: ________________________________________ Date:________________

If Legal Representative, relationship to Patient: ________________________________________________

Witness (optional): _______________________________________________ Date: ______________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____________________________________ Date: ________________

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