



Melanie Mhlstin, M.D.

5310 Hampton Place, Suite 1 | Saginaw, MI 48604

989-321-2655 | Fax: 989-321-2661

Patient name: _____ Date of Birth (DOB): _____

LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print all information. Form must be signed and dated every two years.

Entity Requested to Release Information: MiVision

Purpose of request (who will be authorized to receive information) – I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below:

Who will be authorized to receive information (list the individual/entity who is to receive your Protected Health Information):

Name: _____ Relationship: _____

Phone: _____ Email (optional)*: _____

Name: _____ Relationship: _____

Phone: _____ Email (optional)*: _____

Name: _____ Relationship: _____

Phone: _____ Email (optional)*: _____

Name: _____ Relationship: _____

Phone: _____ Email (optional)*: _____

*Secure Communication – Note that some fax and email transmission method 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.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- Entire patient record OR Check only those items of the record to be disclosed:
- Office notes Record of communicable diseases (HIV, etc.)
- Lab results and pathology Only send the following:
- Financial history _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

- Patient Request Other (please specify): _____



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- This authorization will expire on _____, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the above date: _____
- 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 name (please print): _____

Patient Signature: _____ Date: _____

You have the right to receive a copy of signed authorizations upon request