KALAMAZOO COUNTY
HEALTH AND COMMUNITY SERVICES DEPARTMENT

Promoting Health For All

Appendix 'B'

Authorization Form – Use or Disclosure of PHI

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan. I understand that I am entitled to receive a copy of this form upon signing it. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand that I have a right to revoke this authorization, but that I must send a written revocation to the address below, I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Patient Name:_____ Date of Birth:_____

Kalamazoo County Health & Community Services (3299 Gull Rd, Kalamazoo, MI 49048) is authorized to receive/release my health information from/to the following individuals:

☐ **No one is authorized to receive my health information.**

Authorization granted to:

(Include First & Last name(s) of individual(s))

Provider or Organization authorized to receive/release my health information:

1._____

Name Phone Number

_____

Address (City, State, Zip)

2._____

Name Phone Number

_____

Address (City, State, Zip)

Specific description of information that is to be disclosed (include dates):

_____

_____

Purpose of the disclosure:_____

This disclosure will expire one year from date this document was signed.

_____ _____

Signature (Patient or Parent/Guardian if a minor) **Date**

_____ _____

Printed Name **Relationship (if other than patient)**