Authorization to Discuss and/or
Release My Private Medical Information

I authorize Macomb Physicians Group PLLC, its physicians or staff to discuss the information contained in my medical record, or provide copies of my private medical information to the following person or persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization is effective as of the date signed. I understand that I may revoke this agreement in writing at any time.

It is understood that in the event of my demise, my private medical information will be released to the individual who is named as my power or attorney, personal representative, or by a properly executed order from a court.

Patient's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

Notice of Privacy Practices Acknowledgement

Our Commitment:

- We understand the importance of safeguarding your Protected Health Information (PHI).
- We value your trust and will continue to recognize the importance of holding your PHI as confidential.
- We will hold our employees to strict standards of conduct to ensure the confidentiality of your PHI.
- We maintain physical, electronic and procedural safeguards to comply with state and federal regulations pertaining to PHI.

Our Privacy Notice telling you how this office uses & discloses PHI and what your rights are is posted in the lobby.

(A copy of the Notice of Privacy Practices is available on request)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: