

**MGH FAMILY HEALTH CENTER  
DBA  
MUSKEGON FAMILY CARE  
MEDICAL RECORDS EXCHANGE OF INFORMATION**

**PATIENT AUTHORIZATION FOR PRACTICE TO EXCHANGE  
PROTECTED HEALTH INFORMATION WITH THIRD PARTIES**

By signing this authorization, I authorize **MGH Family Health Center dba Muskegon Family Care** to **disclose or obtain** certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits **MGH Family Health Center dba Muskegon Family Care** to **disclose or obtain** the following individually identifiable health information  
Verbal and/or written exchange of medical, mental health, educational, and psychosocial information (including assessments/diagnoses, observations, rating scales, testing, treatment plans, recommendations) for coordination of care.

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization will expire on \_\_\_\_\_  
(Expiration Date or Defined Event)

When my information is **disclosed or obtained** pursuant to this authorization, it may be subject to **redisclosure** by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that **MGH Family Health Center dba Muskegon Family Care** has acted in reliance upon this authorization. My written revocation must be submitted to **MGH Family Health Center dba Muskegon Family Care's** Privacy Officer at 1700 Oak Avenue, Suite 011, Muskegon, MI 49442.

I understand that signing this authorization allows all of the following:

- (a) **Releasing or obtaining** medical records pertaining to my mental health treatment, including records of any social worker, psychologist or psychiatrist.
- (b) **Releasing or obtaining** medical records pertaining to treatment for alcohol and drug abuse, including information which is protected from disclosure under the regulations in Title 42 of the United States Code of Federal Regulations, Part II.
- (c) **Releasing or obtaining** medical records pertaining to communicable disease, serious communicable diseases and infections as defined by the Public Health Code and applicable rules.
- (d) **Releasing or obtaining** medical records pertaining to human immunodeficiency virus - HIV, acquired immunodeficiency syndrome - AIDS and AIDS Related Complex - ARC.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient (if minor)

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Patient's Date-of-Birth

\_\_\_\_\_  
Date