CITY OF TRAVERSE CITY

AUTHORIZATION TO RELEASE HEALTH INFORMATION
(Health Insurance Portability and Accountability Act (HIPAA) - OTHER)

I, _____, whose date of birth is _____, hereby authorize the use or disclosure of my health information contained in the City's records as follows (attach additional sheets if necessary):

1. Provide a specific description of the information to be used or disclosed that identifies the information in a specific way: _____

2. The person(s), class of persons, or organization(s) that are authorized to disclose the information: _____

3. The person(s), class of persons, or organization(s) that may receive the information: _____

4. The purpose of the requested use or disclosure: _____

5. This authorization shall expire on the following date: _____

I understand that I have the right to revoke this authorization in writing by notifying the City's Privacy Official, the City Clerk. I understand that the revocation is only effective after it is received and logged by the Privacy Official. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I understand that after this information is disclosed, the information disclosed may be subject to re-disclosure by the recipient of the information and may no longer be protected by the HIPAA privacy rule.

I understand that the City may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that I am entitled to receive a copy of this authorization.

Dated: _____

STATE OF)
COUNTY OF)

The foregoing instrument was acknowledged before me this ___ day of _____, 20__, by _____.

_____
Name of Notary:_____
Notary Public, _____ County and
State of _____
Acting in _____ County and
State of _____
My commission expires:_____

RETURN FORM TO PRIVACY OFFICIAL
CITY CLERK
CITY OF TRAVERSE CITY
400 BOARDMAN AVENUE
TRAVERSE CITY, MI 49684

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