MICHIGAN
WOMEN'S HEALTH
A Division of Michigan Healthcare Professionals
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MEDICAL INFORMATION DISCLOSURE AUTHORIZATION

I, _____ , herby authorize and request my physicians, psychologists, hospitals, laboratories and all other health care providers to disclose all information concerning my health to my _____ (son/daughter/husband) , _____ (name) , including, but not limited to, health information considered to be protected under the Health Insurance Portability and Accountability Act of 1996, PL 104-191, as from time to time amended ("HIPAA"). _____ shall be considered my "personal representative" for all purposes of the privacy rule issued by the U.S. Department of Health and Human Services and as required by HIPAA.

I hereby grant full power to _____ to access my medical records and information to the same extent that I am entitled, including the right to disclose the contents to others, and to execute releases in my behalf.

This Medical Information Disclosure Authorization shall be fully binding upon me, my heirs and my personal representatives.

Photocopies of this executed document shall have the same legal force and effect as the original for all purposes.

IN WITNESS WHEREOF, I have executed the MEDICAL INFORMATION DISCLOSURE AUTHORIZATION this _____ day of _____ , 20____

SIGNATURE OF PATIENT: _____