University Medical Specialties
9045 US 31, Berrien Springs, MI 49103
269-473-2222 Fax 269-473-6880

Patient Name: _____ Phone Number: _____
Date of Birth: _____

I hereby authorize University Medical Specialties to use or disclose the following **Protected Health Information (PHI):**

Description of information to be released: _____
_____

Person or place receiving PHI:

_____
_____
_____
_____

Person or place sending the PHI:

_____
_____
_____
_____

This disclosure is being made for the following reason:

[ ] At the request of the patient
[ ] Other: _____

This authorization shall be in effect until: (Check one of the following)

[ ] The following expiration event: _____
[ ] Date: _____

I understand that I have the right to:

- Inspect or copy my PHI to be used or disclosed as permitted under federal law.
- Refuse to sign this authorization.
- Revoke this authorization in writing at any time by sending notification to:

  Privacy Official
  9045 US 31
  Berrien Springs, MI 49103

I understand that:

- Information used or disclosed because of the authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law.
- The practice will not condition my treatment on whether I provide authorization for the requested disclosure

_____ _____
Signature of Patient or Personal Representative Date:

_____ _____
Name of Personal Representative Description or Personal Representative's Authority