MMS HIPAA Compliance Form

Patient Authorization to Disclose Health Information

Patient Name: _____ _____ _____
Please print (First Name) (Middle Initial) (Last Name)

Street Address: _____ _____ _____ _____
(City) (State) (Zip Code)

Hospital Patient was seen at: _____ Date(s) of Service: _____

Patient's Account Number: _____

Patient's Date of Birth: _____ Last 4 Digits of Patient's Social Security No.: _____

1. I authorize the use of disclosure of the above-named individual's health information, as described below.

2. Medical Management Specialists is authorized to make the disclosure.

3. The type and amount of information to be disclosed is as noted below (check one):

   a. ☐ Entire record, or
   b. ☐ Only the following information:

   _____

4. The information may be disclosed to, and used by, the following individuals or organizations:

   Name: _____

   Address: _____

   City, State, Zip: _____

5. This information is being disclosed/used for the following purpose(s):

   _____

6. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

7. I understand that I need not sign this form in order to ensure health treatment, payment enrollment in my health plan or eligibility for benefits.

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8. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Medical Management Specialists, 4100 Embassy Dr SE, Suite 200, Grand Rapids, MI 49546, Attention: Billing Manager.

9. This authorization expires (check one):
   a. ☐ Six (6) months after the date this Authorization has been signed, as noted below, or
   b. ☐ On the following date, event or condition:

      _____

10. Please keep a copy of this Authorization Form.

Signature of Patient or Legal Representative _____ Date: _____

If signed by legal representative, relationship to patient: _____

Signature of Witness: _____ Date: _____