CRYSTAL LAKE HEALTH CENTER

6227 Benzie Hwy
Benzonia, MI 49616
Phone: 231-882-9661 Fax: 231-882-9616
www.crystallakeclinic.com

Authorization for Disclosure of Medical Information

I,_____ whose date of birth

is_____ authorize **Crystal Lake Health Clinic** to release protected

health information to the following person(s):

List individual(s) who authorization is granted to: (please limit access to two individuals)

1.

Name	Relationship	Home/Cell Phone

2.

Name	Relationship	Home/Cell Phone

Additional Comments/Requests:

_____

_____

This release is effective until revoked. I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer at the address above. I understand that revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

X _____ X _____

Signature of Patient or Personal Representative | Date