



(\* Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.)

I understand that if I give permission, I have the right to change my mind and **revoke** it. This must be in writing to the Facility or MDCH Program that maintains the individual's records that I authorized on Page 1 of this form. I also understand that any uses or disclosures already made with my permission cannot be taken back.

If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.)

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**Date, Event or Condition**

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.

<b>Legal Representative's Name</b> (If applicable)	<b>Legal Representative's Relationship to Individual</b> (A letter of authority may be requested.)	
<b>Signature of Individual or Legal Representative</b>	<b>Date</b> / /	
<b>Signature of Witness</b>	<b>Date</b> / /	

**MDCH Use Only**

<b>This authorization was revoked:</b>	
/ /	
<b>Signature</b>	<b>Date</b>

**AUTHORITY:** This form is acceptable to the Michigan Department of Community Health as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002.  
**COMPLETION:** Is Voluntary, but required if disclosure is requested.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.