Smiles OF GRAND RIVER

(734) 707-8764
55840 Grand River Ave. Ste 350
Lyon Township, MI 48165

HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although the revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Authorization of Records Release

This signature page is designed for you to establish limitations on what information we can share with people **other than your insurance company or doctors who coordinate your care.** If you have certain family members or caregivers that normally assist you in either your health care or financial decisions, you may wish to include them below. **If you do not authorize anyone, be aware that we will not be allowed to answer any questions regarding your care, including billing, to anyone but you (including your spouse, siblings, grandparents, children and/or caregivers).**

I authorize the person(s) named below to discuss my care in my absence and obtain my medical records if necessary. (This does not include doctors who are involved with my case). I understand this authorization is in effect in perpetuity unless I revoke the authorizations in writing.

Name Relationship Date

1)_____

2)_____

◯ I do not authorize any communication to anyone but myself.

_____

Signature Date