# MICHIGAN ABILITIES CENTER

**PHYSICAL MEDICINE AND REHABILITATION**
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# HIPAA Release of Information

**AUTHORIZATION FORM**

I, _____hereby authorize WSUPG and its affiliates, its employees and agents (collectively WSUPG), to release to Michigan Abilities Center Physical Medicine and Rehabilitation (MAC PMR) (at the above email, fax, or address) my personal health information maintained by the Wayne State University Physician Group (e.g., information relating to the diagnosis, treatment and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me: _____ [DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to MAC PMR. However, this authorization may not be revoked if MAC PMR, its' employees or agents have taken action on this authorization prior to receiving my written notice. It shall remain valid no longer than is reasonably necessary to accomplish the purpose for which it was given. I understand that records released for the above purpose will be treated with confidentiality. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

Name of Client: _____ Date of Birth_____

Signature of Client: _____

Date:_____

If applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal representative of the person identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the person's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____