MID COUNTY PHYSICIANS MEDICAL GROUP

Mid County Physicians Medical Group ("MCPMG") is dedicated to ensuring the protection of the identifying and medical information ("PHI") of Patients. MCPMG is obligated to obtain authorization from Patients and their responsible representatives, guardians, conservators and health care agents (collectively, "Representatives") prior to releasing identifying and medical information to third parties in certain instances. By signing this authorization, you are agreeing that MCPMG may release certain information to the individual or entity identified below for the purposes described below.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, the undersigned *PATIENT* OR Patient's *LEGAL REPRESENTATIVE* authorize MCPMG to disclose the following information to:

_____ _____

Name of Person Authorized to Receive Access to Patient PHI *Relationship to Patient*

☐ CLAIMS STATUS and PAYMENT INFORMATION ☐ AUTHORIZATION STATUS

☐ MEMBER STATUS and DEMOGRAPHIC INFORMATION

I understand that I am not required to sign this authorization and that if I should choose not to sign this authorization Patient's treatment and enrollment in Patient's health plan will not be affected in any way.

If I choose to sign this authorization, I may revoke it at any time by providing a written notice of revocation to MCPMG. I understand MCPMG shall not be liable for its disclosure of information under this authorization if such disclosure is made in reliance upon this authorization prior to the date MCPMG receives my notice of revocation of this authorization. I understand that if my information is disclosed as requested herein, it may be redisclosed and no longer be protected by federal privacy rules.

This authorization will expire automatically upon _____ or on _____
[Specify Event] [Specify Date]

_____ Patient Telephone No: _____
PATIENT NAME Patient Mailing Address: _____
_____

_____ _____
PATIENT SIGNATURE EFFECTIVE DATE OF AUTHORIZATION

****

This section should only be used if form is being completed and signed by Patient's legal representative. A copy of the Power of Attorney must be on file with MCPMG or accompany this form BEFORE the release by Patient's Representative is valid.

_____ Rep. Telephone No: _____
LEGAL REPRESENTATIVE'S NAME Rep. Mailing Address: _____
_____

_____ _____
LEGAL REPRESENTATIVE SIGNATURE EFFECTIVE DATE OF AUTHORIZATION