MICHIGAN PRIMARY CARE, PLLC

HIPAA RELEASE FORM

Patient Name:_____

DOB:_____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse, family, friends or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

Name	Relation	Phone #

Name	Relation	Phone #

Name Relation Phone #

Name Relation Phone #

If at any time this authorization changes, please inform the office.

Patient Signature Date