
Macomb Township Authorization Form

Note: This form is specifically for an employee to sign to allow the group health plan to disclose PHI that requires an authorization.

I authorize the Macomb Township Group Health Plan:

1. To disclose _____
(description of health information to be disclosed; for example, diagnosis, treatment and insurance information).
2. To _____
(for example, name of health care provider).
3. For the purpose of _____
(description of all purposes for the disclosure; for example, to bill and obtain payment from a provider).

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may revoke this authorization at any time in writing by sending a written request to:

Mark H. Grabow, Supervisor
Macomb Township
54111 Broughton Road
Macomb, MI 48042

I am aware that a revocation will not have any effect on any use or disclosure of protected health information by the Macomb Township Group Health Plan before it received the revocation.

This authorization is valid for two years from the date signed.

I understand that if protected health information about me is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

Signature of Employee, Spouse, Dependent or Representative

Date

Name of Employee, Spouse or Dependent

Name of Personal Representative (if applicable)

Relationship of Personal Representative to Employee, Spouse or Dependent