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**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize East Lansing Orthopedic Association to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits (person releasing information): _____

To use or disclose to (person receiving information): _____

The following individually identifiable health information:

All medical records Other: _____

This authorization will expire on: indefinite ___month(s) ___year(s) Date: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that East Lansing Orthopedic Association has acted in reliance upon this authorization. My written revocation must be submitted to East Lansing Orthopedic Association's Privacy Officer at 3394 E. Jolly Rd, Suite A, Lansing, MI 48910.

Patient's Name

Date of Birth

Signed by: _____
Signature of Patient OR Legal Guardian

Relationship to Patient

Print Name Legal Guardian if applicable

Date