Vinod Sanghi MD PC
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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I voluntarily consent to authorize my health care provider Dr. _____ to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: **Grace Endocrine Services**

☐ **6540 Park Ave, Allen Park, MI 48101** ☐ **21510 Harrington Street Suite 303, Clinton Twp, MI 48036**

Purpose: I authorize the release of my health information for the following specific purpose:

_____

Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

☐ Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

Only the following records or types of health information:

Term: I understand that this Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20___.

☐ Until the Provider fulfills this request.

☐ Until the following event occurs: _____

Re-disclosure: I understand that my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Patient Signature _____ **Date** _____

If Individual is unable to sign this Authorization, please complete the information below

Name of Guardian _____

Legal Relationship_____

Representative Signature: _____ **Date:** _____