**West Bloomfield Internal Medicine, P.L.L.C.**
6014 West Maple Road,
West Bloomfield, MI 48322
Telephone: (248) 855-7453 / Fax: (248) 855-7458

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JAMES BRAGMAN D.O.

# HIPPA PRIVACY AUTHROIZATION FORM

Date: ________________________________

Patient Name: ________________________________________________ Patients DOB: ______/_______/_______

Address: ________________________________________________________________________________________________

City: ________________________________________ State: _______________ Zip: __________________________________

I authorize ___________________________________________________________________________ to disclose the protected health information described below to West Bloomfield Internal Medicine PLLC.

This authorization for release of information covers the period of healthcare from: _________________ to ___________________. I authorize the release of my complete health records except for the following:

_______________________________________________________________________________________________________.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

**Patient Signature**: ________________________________________________ Date: _______________________

Print Patient Name: ________________________________________________

Authorized Patient Representative Signature: ____________________________________ Date: ________________

Print Authorized Patient Representative Name: ________________________________

******PLEASE FAX REQUESTED INFORMATION TO 248-855-7458******