Midwest Health Group, LLC.

Authorization of Disclosure of Protected Health Information

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P 573.747.1510 F 573.747.1512
www.midwesthealthgroup.com

Persons Authorized to Receive Information:

Health information that Midwest Health Group, LLC collects or receives about me may be disclosed to the following persons:

Name of Person	Relationship

Use and Disclosure of Information:

_____ (Please Initial) I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Midwest Health Group, LLC.

_____ (Please Initial) I do not authorize the following information to be disclosed to any other parties except to me as the patient. (Please specify) _____

You may revoke or terminate this authorization by submitting a written revocation to Midwest Health Group, LLC. to the attention of the Privacy Official or other authorized representative. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

If you have an answering machine, may we leave messages regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Midwest Health Group, LLC? (Check one)

_____ Yes _____ No _____ N/A

If "No", how else may we contact you regarding this information?

_____

Other comments:

_____

Patient Name	Patient or Authorized Representative	Date

Witness Date