Hygieia Clinic Michigan, PC
28807 Eight Mile Road, Suite 102
Livonia, MI 48152
(734) 743-2838

Communication and Medical Information Authorization

Patient Name _____

Date of Birth _____ Hygieia ID _____

I give my permission for Hygieia Clinic Michigan, PC (d-Nav Care Center) to disclose my health information described in Section 1 to the persons or organizations that I have specified in Section 2. Such authorization is being made at my request.

SECTION 1: HEALTH INFORMATION

I give d-Nav Care Center permission to disclose the following health information:

☐ My complete health records including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

-OR-

☐ My complete health records, excluding any of the following information (*please specify below*):

_____

_____

_____

SECTION 2: PERSONS WHO CAN RECEIVE MY HEALTH INFORMATION

Please ensure that you include members of your care team such as your primary care provider or an endocrinologist.

Care Team Member	Name	Phone Number	Permission to contact?
Primary Care Provider			☐ Yes ☐ No
Endocrinologist			☐ Yes ☐ No

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I authorize d-Nav Care Center to share my health information with the following persons:

	Name	Relationship	Phone Number
1.			
2.			
3.			
4.			
5.			

I understand that the persons listed above may not be covered by state/federal rules governing the privacy and security of data and may be permitted to further share my health information.

SECTION 3: DURATION OF AUTHORIZATION

This authorization to share my health information is valid:

- ☐ For all past, present, and future periods
- ☐ From _____ to _____
- ☐ From the date of signature until the occurrence of the following event:

  _____

I understand that I am permitted to revoke this authorization to share my health information at any time and I can do so by submitting a request in writing to Dr. Israel Hodish, MD Medical Director at d-Nav Care Center at 28807 Eight Mile Rd Suite 102, Livonia, MI 48152. However, in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health information.

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SECTION 4: AUTHORIZATION FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication (which may include a link to an online portal) to contact me as needed. I understand that my service provider may charge me for such communication and that electronic communication, while very convenient, may not always be very secure.

I authorize to be contacted via text message at _____

I authorize to be contacted via electronic mail at _____

☐ I prefer to be only contacted via US Mail and telephone number on file.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits that I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Patient Signature _____ Date _____

Witness _____

If this authorization is being completed by a person with legal authority to act on the patient's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of Person Completing the Authorization _____

Signature of Person Completing the Authorization _____

Date _____

Describe below how this person has legal authority to sign this authorization:

_____

_____