AUTHORIZATION FOR THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION.

By signing below, I hereby authorize my health information, as more specifically described as follows:

_____ (the "Protected Health Information"), to be used or

disclosed for the following purposes: _____.

[If the use or disclosure is at the patient's request, insert "At the Patient's Request instead of a specific purpose.]

The specific person or class of persons who are authorized to use or disclose my Protected Health Information are:

_____

_____

The person or class of persons to whom this office may use or disclose my Protected Health Information are:

_____

This Authorization shall expire on:

I understand that I have the right to revoke this Authorization, if the revocation is on writing , except of

- This office has taken action in reliance upon this Authorization; or
- This Authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to contest a claim made under the insurance policy.

I understand that I may revoke this Authorization by delivering written notice to

_____

I understand that my Protected Health Information that is used or disclosed pursuant to this Authorization may be subject to re-disclosure by the person(s) you have disclosed it to, and the privacy of my Protected Health Information will no longer be protected.

I acknowledge that I have read and understand this Authorization. I authorize the use of disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____ _____

Witness Date

_____ _____

Patient Signature or Authorized Representative Signature Date

Description of authorized Representative's authority to sign for the patient:

_____

ANGELA BULLY, M.D. TAMMIE L. BULLY, M.D.

29425 Northwestern Hwy #330
Southfield, MI 48034
248-727-1990 (Office)
833-599-8724 (Fax)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT'S FULL NAME:_____ MAIDEN NAME:_____
Last First Initial

DATE OF BIRTH:_____ LAST 4 DIGITS OF SS#_____ GENDER: M/F TELEPHONE# ( )_____

ADDRESS: STREET:_____

CITY:_____ STATE:_____ ZIP:_____

I, _____ HEREBY AUTHORIZE _____,

IT'S DIRECTOR OR AGENT, TO DISCLOSE INFORMATION CONTAINED IN THE MEDICAL RECORD OF THE PATIENT IDENTIFIED ABOVE, WHICH INCLUDES INFORMATION THAT MAY BE STORED IN A PAPER AND/OR ELECTRONIC FORMAT AS SET FORTH BELOW. HOWEVER, SUCH NOTES MAY CONTAIN INFORMATION ON GENERAL MEDICAL CARE; ALCOHOL AND DRUG ABUSE TREATMENT; PSYCHOLOGICAL AND SOCIAL WORK COUNSELING; HUMAN IMMUNODEFICIENCY VIRUS (HIV) OR ACQUIRED IMMUMODEFICIENCY SYNDROME (AIDS) OR AIDS RELATED COMPLEX (ARC); COMMUNIABLE DISEASES OR INFECTIONS; INCLUDING SEXUALLY TRANSMITTED DISEASES, VENEREAL DISEASES, TUBERCULOSIS AND HEPATITIS; DEMOGRAPHIC INFORMATION AND TREATMENT RECEIVED AT OTHER HEALTH CARE PROVIDERS.

NAME OR TITLE OF PERSON/ORGANIZATION AND ADDRESS TO WHOM INFORMATION IS TO BE:

☐ DISCLOSURE TO:_____ ☐ RELEASE FROM:_____

_____ _____

_____ _____

_____ _____

THE PURPOSE OR NEED FOR SUCH DISCLOSURE:

____AT THE REQUEST OF THE PATIENT _____PERSONAL USE _____CONTINUATION OF CARE ____ATTORNEY

____WORKMAN'S COMPENSATION _____INSURANCE _____DISABILITY ____OTHER_____

SPECIFIC INFORMATION TO BE DISCLOSED/OBTAINED AS RELATED TO ABOVE

____ER MEMO ____OUTPATIENT VISIT ____X-RAY/LAB ____DISCHARGE SUMMARY ____IMMUNIZATIONS

____DIAGNOSIS/DATES ____OTHER (SPECIFY) _____

THIS AUTHORIZATION IS VALID ONLY IF RECEIVED BY DR. ANGELA BULLY'S OFFICE WITHIN 60 DAYS OF THE DATE SIGNED. THIS AUTHORIZATION EXPIRES WHEN THE PATIENT INFORMATION IS DISCLOSED AS PERMITTED IN THE AUTHORIZATION, OR ON_____ (DATE CANNOT EXCEED ONE YEAR FROM DATE SIGNATURE BELOW).

I MAY REVOKE THIS AUTHORIZATION AT ANYTIME. REVOCATIONS TO THIS MUST BE PRESENTED IN WRITING. REVOCATION WILL NOT APPLY TO THE INFORMATION THAT HAS ALREADY BEEN RELEASED PURSUANT TO THIS AUTHORIZATION.

SIGNATURE: _____ RELATIONSHIP (IF OTHER THAN PATIENT) _____
PATIENT, PATIENT OF MINOR, LEGAL GUARDIAN
REPRESENTATIVE, PERSON UNDER A POA*

DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

_____ _____

Witness Date

_____ _____

Patient Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On_____, 2022, _____ presented this Acknowledgement of Receipt of Notice of Privacy Practices Form to _____ (to "Patient"). The Patient refused to provide a signature when requested.

CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your health information in our possession (collectively "Protected Health Information").

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please carefully review the Notice of Privacy Practices Form that this office has prepared and is furnishing to you today. Please also see our Notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment", "Payment" and "Health care operations".

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICES FORM MAY BE REVISED BY THIS OFFICE FROM TIME TO TIME. ANY SUCH REVISED NOTICE OF PRIVACY PRACTICES FROM WILL BE MADE AVAILABLE TO YOU BY CONTACTING. YOUR PHYSICIAN.

YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT ARE AVAILABLE TO YOU WITH RESPECT TO THIS OFFICE'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. THESE RIGHTS INCLUDE YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.

BE SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ, AND UNDERSTAND THIS CONSENT AND THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FROM TO TAKE WITH YOU.

_____ _____

Witness Date

_____ _____

Patient Signature Date

Cancellation Policy

ANGELA BULLY, M.D. TAMMIE L. BULLY, M.D.

Patient Name: _____

I understand that as a patient of this practice, it is my responsibility to notify Dr. Bully's office if I am unable to keep my scheduled appointment. Cancellation of my appointment in a timely manner allows other patients an opportunity to get same day service or an earlier appointment. If a cancellation is not made within twenty-four hours of a scheduled appointment, a $40.00 (forty dollar) fee ***may be applied*** and will be due before my next visit. My signature on this document verifies that I acknowledge, understand, and agree to comply with office policy, and that any questions regarding this policy have been answered.

_____ _____

Signature of Patient Signature of Witness

_____ _____

Date Signed Date Signed