ALPHABET SHUFFLE, LLC

Authorization for the Release and/or Discussion of Protected Health Information

Client Name: _____ Birth Date: _____/_____/_____

Authorization

1. I, _____, hereby authorize:
   (Name of Patient or Patient's Legally Authorized Representative)

   Alphabet Shuffle, LLC, 805 1st Street, Menominee, MI 49858, Phone: (906) 424-4476,
   Text Line: (715) 330-2291, Fax: (906) 424-4480, Email: misssherry2@yahoo.com

2. To release and/or discuss the following information:
   - ☐ My Complete health record (including but not limited to diagnoses, prognosis, treatment, and billing, all conditions)
   - ☐ Diagnosis
   - ☐ Appointment Date/Time
   - ☐ Billing

3. To:

Name	Relationship	Phone Number

I authorize the use of a copy of this form for the disclosure of the information described above.

Signature: I have carefully read and understand the above information and do herein consent to its disclosure. I understand that the person(s) listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them. I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to Alphabet Shuffle, LLC, cancelling the authorization. If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission. I understand that I do not have to give permission to share my information with the person(s) listed in Section 3. I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive. This authorization expires one year from today's date.

Signed: _____ Relationship: _____ Date: ____/____/_____