PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

MICHIGAN STATE UNIVERSITY HEALTHTEAM

Patient Name (Last, first)_____

Address: _____

Date of Birth:_____**Phone #** _____

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION

FROM: _____
Person/entity authorized to disclose this information

_____
Address

_____

_____
Phone/Fax Number

TO: _____
Person/entity authorized to receive this information

_____
Address

_____

_____
Phone/Fax Number

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

☐ ALL information contained in my medical record (including but not limited to list below)_____
Specify date range, if applicable

OR

☐ ONLY the specific information checked below:

☐ Progress Notes-specify date(s)_____
☐ Lab Reports–specify date(s)_____
☐ Physical Exam–specify date(s)_____
☐ ER Reports-specify date(s)_____
☐ Mental Health –specify date(s)_____
☐ Information about serious communicable diseases and infections (STD, TB, HIV, AIDS, and hepatitis)
☐ Other – specify_____

☐ X-ray/CT/MRI–specify date(s)_____
☐ Operative Reports–specify dates(s)_____
☐ Discharge Summary-specify date(s)_____
☐ Consultations-specify date(s)_____
☐ Substance Abuse Program Records –specify date (s)
_____
☐ Info from other health care providers/facilities -specify
_____

PURPOSE OF THIS DISCLOSURE (check one):

___Continuing care ___Insurance ___Legal ___Disability ___Patient Request
___Other (specify)_____

I ACKNOWLEDGE that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed by them and no longer protected by the Privacy regulations.

I ACKNOWLEDGE that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.

I ACKNOWLEDGE that I may revoke this Authorization in writing at any time by contacting the disclosing party (MSU HealthTeam or other entity) except to the extent that action has been taken in reliance on this Authorization. This Authorization expires:_____ (or six months from the date signed).

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient)

PROVIDE COPY TO PATIENT (IF APPLICABLE)