PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

MICHIGAN STATE UNIVERSITY HEALTHTEAM

Patient Name (Last, First, Middle) _____

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

I authorize the disclosure of my protected health information as specified below:

FROM: _____
MSUHT Department/Clinic who has the information

_____
Address

_____
City, State, Zip Code

_____
Phone/Fax Number

TO: _____
Person/office you want to receive this information

_____
Address

_____
City, State, Zip Code

_____
Phone/Fax Number

☐**Check here** if you are authorizing oral consultation about your health information only.

SPECIFY THE INFORMATION TO BE DISCLOSED: Please specify date(s)

☐Office Visits _____ ☐Discharge Summary _____
☐Lab Reports _____ ☐X-Ray/CT/MRI_____
☐Consultations _____ ☐Immunizations _____
☐Physical Therapy _____
☐Information from other healthcare providers/facilities (please specify)_____
☐Other (please specify)_____

I specifically authorize release of information related to the following that may be contained in the above disclosures, if applicable to me:

☐Mental Health ☐HIV/AIDS ☐Substance Abuse Treatment

PURPOSE OF THIS DISCLOSURE:

☐Continuing Care ☐Insurance ☐Legal ☐Disability ☐Patient Request ☐Workers Comp
Other (please specify)_____

I UNDERSTAND 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 many no longer be protected from further disclosures.

I UNDERSTAND 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 UNDERSTAND that I may revoke this Authorization at any time by contacting MSU HealthTeam 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 **(Required)** Date **(Required)**

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

PROVIDE COPY TO PATIENT (IF REQUESTED)

30May2017