University Health and Wellbeing
MICHIGAN STATE UNIVERSITY

PATIENT AUTHORIZATION FOR DISCLOSURE OF ADD/ADHD HEALTH INFORMATION

Patient Name (Last, First) _____ **PID#**_____

Address: _____

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

I authorize disclosure of protected health information about me as specified below.

FROM: _____
Person/entity authorized to disclose this information

_____
Address

_____

_____
Phone/Fax Number

TO: Campus Health Services
Person/entity authorized to receive this information

ATTN: MEDICAL RECORDS
463 East Circle Drive
East Lansing Michigan 48824
Address
(517)353-9153, Fax: (517)432-9460
Phone/ Fax Number

Please send the following information.
SPECIFIC INFORMATION TO BE DISCLOSED: (If present in the medical record)

1. **Evaluation and diagnosis of ADHD**
2. **Recent office notes regarding ADHD medication refills.**
3. **Neuropsychiatric Testing**

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

☒ **Mental Health** ☐ **Substance Abuse Treatment**

PURPOSE(S) OF THIS DISCLOSURE:

_X_ Continuing Care ____Insurance ____Legal ____Disability _____Workers Comp ____ Patient Request
____Other (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, my health information disclosed here may 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 Olin Health Center, except to the extent that action has already been taken in reliance on this Authorization. Olin Health Center will make no further disclosures to the above person/entity without a new authorization. Olin Health Center can rely on this authorization until it is revoked or expires. 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 REQUESTED)

Rev 03/2024