Student Health Services
University Health and Wellbeing
MICHIGAN STATE UNIVERSITY

Medical Record Department
Phone: 517-353-9153 | Fax: 517-432-9460

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (Last, First)__________________________________**PID# or SS#**____________________

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: ___________________________________
Person/entity authorized to receive this information

____
Address

____

____
Phone/Fax Number

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

SPECIFY THE INFORMATION TO BE DISCLOSED:

- ☐ Office Visits ________________________________
- ☐ Lab Reports ________________________________
- ☐ Ray/CT/MRI ________________________________
- ☐ Immunizations ______________________________
- ☐ Physical Therapy ___________________________
- ☐ ER Reports _________________________________
- ☐ Consultations ______________________________
- ☐ Info from other health care providers/facilities (specify): ______________________________
- ☐ Other: ____________________________________

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 and Related Diseases** ☐ **Substance Use Treatment**

PURPOSE(S) OF THIS DISCLOSURE:

_________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 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)