

**PATIENT AUTHORIZATION FOR DISCLOSURE
OF HEALTH INFORMATION**



Patient Name (Last, first): _____

Address: _____

Date of Birth: _____

Phone #: _____

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION BETWEEN BOTH PARTIES INDICATED BELOW.

MSU Department of Psychiatry

B119 West Fee Hall

Address

East Lansing, MI 48824-1315

Phone: (517) 353-3070

Fax: (517) 432-3603

Phone/Fax Number

Address

Phone:

Fax:

Phone/Fax Number

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

ONLY the specific information checked below:

- Ongoing communication, as needed, between the parties specified above
- Verbal exchange of information
- Progress Notes
- Psychiatric/Psychological Assessments
- Psychotherapy Notes
- Lab Reports
- Medications
- Psychological Testing

- Treatment Summaries
- Discharge Summary
- Consultations
- Information about serious communicable diseases and infections (STD, TB, HIV, AIDS and Hepatitis)
- Information regarding substance abuse-specify _____
- Other-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 upon completion of treatment or as noted: _____.

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)