MSU Health Care
Partnering with HENRY FORD HEALTH

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient name (Last, First, Middle): _____

Date of Birth: _____ Phone Number: _____

Address _____

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

FROM:	**TO:**
MSU Health Care clinic who has the information	Person/Clinic you want to receive this information
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone/Fax Number	Phone/Fax Number
	Email

SPECIFY THE INFORMATION TO BE DISCLOSED:

Between the dates of: _____

- ☐ Discharge Summary
- ☐ Imaging (X-Ray, CT, MRI, etc)
- ☐ Immunizations
- ☐ Other (please specify) _____
- ☐ Lab Reports
- ☐ Office Visits
- ☐ Physical Therapy

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

☐ HIV/AIDS ☐ Mental Health ☐ Substance Abuse Treatment

PURPOSE OF THIS DISCLOSURE:

☐ Continuing Care ☐ Disability ☐ Insurance ☐ Legal ☐ Patient Request ☐ Workers Comp

☐ Other (please specify) _____

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- ☐ 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 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 this request for copies of medical records may be subject to reproduction fees in accordance with federal and state law.
- ☐ I UNDERSTAND that I may revoke this Authorization at any time by contacting MSU Health Care 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

RETURN TO
MSU Health Care Medical Records

804 Service Road
Suite A118
East Lansing, MI 48824
F: 517.432.2364
E: ht.medicalrecords@msu.edu