PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

MSU Health Care

Patient Name (Last, First, Middle) _____

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

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

FROM: _____
MSU Health Care 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

_____
Email

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

RESTRICTION: Only medical records originating through this healthcare facility will be copied.

☐ Office Visits_____ ☐Discharge Summary_____
☐ Lab Reports_____ ☐X-Ray/CT/MRI _____
☐Immunizations _____ ☐Physical Therapy_____
☐ 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 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 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).

I UNDERSTAND this request for copies of medical records may be subject to reproduction fees in accordance with federal and state law.

_____ _____
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