**PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

MICHIGAN STATE UNIVERSITY HEALTHTEAM

**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**

**909 Fee Rd, Room B119**
**Address**

**East Lansing, MI 48824-6537**
**Phone: (517) 353-3070**
**Fax: (517) 884-1817**
**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):

**X** 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)**