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 between the parties below:

MSU Department of Psychiatry	_____
909 Wilson Rd, West Fee Hall Room B119 **Address**	_____ **Address**
East Lansing, MI 48824-6537 **City, State, Zip Code**	_____ **City, State, Zip Code**
Phone: (517) 353-3070 **Fax:** (517) 884-1817	**Phone**: **Fax:**

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

☐ Ongoing Communication, as needed, between the parties named above

☐ All of my behavioral health information _____

☐ Progress Notes / Encounters _____ ☐ Treatment Summaries _____

☐ Psychiatric / Psychological Assessments/ Testing _____

☐ Psychotherapy Notes _____ ☐ Lab Reports _____ ☐ Immunizations _____

☐ Medications _____ ☐ Consultations _____

☐ Information from other healthcare providers/facilities (please specify)_____

☐ Other (please specify)_____

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 not 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 the Psychiatry Clinic except to the extent that action has been taken in reliance on this Authorization. This Authorization expires: _____ (or one year 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