CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient:_____ Birthdate: _____/_____/_____
SSN: _____ Phone number: _____
Current address:_____ City: _____ State: _____ Zip Code: _____

Release TO/FROM:
_____
_____
_____

Release TO/FROM:
_____
_____
_____

I hereby authorize the release of the health information contained in the patient records for the patient named above to the recipient named above. I understand that this may include treatment for physical and mental illness, alcohol, and/or drug abuse, and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient psychotherapy notes. Release of psychotherapy notes requires a separate authorization.

Information to be released (check one):

____ Any and all records ____ Immunization records ____ Most recent pap smear ____ Last office visit

____ Most recent lab tests ____ X-rays ____ Other _____

Purpose of disclosure (check one):

____ Transfer of care ____ Social Security benefits ____ Disability determination ____ Workers compensation

____ Attorney use ____ Insurance application ____ Patient personal use ____ Other _____

This authorization expires: ____ One year from the date signed - OR- __ on ___/____/____

I understand that I may revoke this authorization at any time, except to the extent the action has been taken thereon, by filing a written request with CMU Medical Education Partner Medical Records Department. I understand that my health information that is used or disclosed under this authorization may be re-disclosed by the recipient to another party and is no longer protected by the federal privacy rule. I understand this organization's ability or inability to condition treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or copy the health information being disclosed. I understand that I may be assigned a charge for copying my health information. I have read and understand this authorization.

Signature _____ ___Patient ___Legal representative* Date_____

Relationship to patient _____ Legal representative DOB ____/ _____/_____

Driver's License #, State ID#, or SSN _____ Witness _____

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e., court-appointed guardian, durable power of attorney for healthcare). Exception: parent signing for a patient under the age of 18 years old. For a deceased patient, a court entry or order appointing the (fiduciary, executor, or administrator, or letters of appointment received from Probate Court MUST accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate coupled with the documents naming the administrator or executor of the estate.

INCOMPLETE FORMS WILL NOT BE PROCESSED.