CARLS CENTER FOR CLINICAL CARE AND EDUCATION

CENTRAL MICHIGAN UNIVERSITY

Health Professions Building 1101
Mount Pleasant, MI 48859
Phone: 989-774-3904
Fax: 989-774-1891
chp.cmich.edu/carlscenter

Audiology Clinic
Autism Center
Fall and Balance Clinic
Physical Therapy
Psychological Training and Consultation Center
Speech-Language Pathology Clinic

Authorization to Request/Release Protected Health Information

Client Name: _____ Date of Birth: _____ MR#: _____

I authorize the release/request of the following health information about me:

- ☐ Audiology Reports
- ☐ Psychology Reports
- ☐ Speech-Language Reports
- ☐ Treatment Documentation
- ☐ Billing Statements
- ☐ Claims Resolution
- ☐ Consultations
- ☐ Other:

☐ **To:** or ☐ **From:**

☐ **From:** or ☐ **To:**

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_____
_____
_____
_____

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL(S) TO WHOM INFORMATION IS TO BE RELEASED:

- This information may be disclosed until (ending date) _____. If this date is left blank, the authorization will automatically expire one year from the date I sign below.
- I understand that if the person(s) or entity(ies) that receive the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore, I release Central Michigan University, its faculty and staff from all liability arising from the disclosure of my health information.
- I understand that I may inspect or request copies of any information disclosed by this authorization.
- I understand that I may revoke this authorization by notifying, in writing to CMU, except to the extent that an action has been taken on it.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits from CMU.
- I understand that the information in my health record may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ _____
Patient/Client/Parent/Guardian Signature Date

_____ _____
Printed Name of Person Signing Relationship to Patient