CARLS CENTER FOR CLINICAL CARE AND EDUCATION

1101 Health Professions Building
Mount Pleasant, MI 48859
Phone: (989) 774-3904 (Voice/TTY)
Fax: (989) 774-1891

Audiology Clinic
Speech-Language Pathology Clinics
Summer Specialty Clinics
Physical Therapy Clinics
Psychological Training and Consultation Center

Consent to Release of Medical Information

PATIENT:_____M.R.#:_____

PATIENT'S PHONE #: _____ DATE OF BIRTH: _____

You may, at any time, request and receive a copy of your diagnostic service and/or treatment reports. If you would like information shared with any healthcare provider or anyone else, you must complete this form.

I. Information About the Records to be Disclosed

By signing below, I authorize CMU's Carls Center to release or obtain my medical records as described below.

Recipients of Information

Please list everyone who may receive information about the care you received through CMU's Carls Center. Be sure to include your primary care physician and your referring physician/clinician. (You may also request that a copy be sent to others who need this information, such as a school speech language pathologist or audiologist, therapist, case worker, other doctor involved in your care, and other adult family members or designates.)

Name & Title:	**Address:**	**Ph #:** ☑ **if OK to leave voice mail messages ▼**
		[ ] ☐
		[ ] ☐
		[ ] ☐
		[ ] ☐

The Carls Center has medical records that include information about treatment and medications that have been prescribed for me by treating physicians. These records may include information relating to treatment for communicable diseases and infections, mental health, HIV and acquired immunodeficiency syndrome (AIDS), drug or alcohol dependency or genetic conditions. Unless I have indicated any restrictions below, I am permitting the Carls Center to disclose all of my medical records to the recipients

named above. **Restrictions**. **Do not** release to the recipients listed on page 1 the following records (INSTRUCTIONS: Please list any information release restrictions, such as records or prescriptions from certain doctors, or records from a specific range of dates, etc.): _____

_____

_____

_____

Specific purpose of the disclosure. If you would like to specify a purpose for the disclosure (such as "to resolve a claim for benefits" or "for purposes of a legal case review"), please list the purpose; otherwise, the purpose will simply be deemed to be upon your request: _____

_____

_____

Expiration date. Unless you indicate a different expiration date, this authorization will expire after one (1) year. If you would like the authorization to be valid for a longer period of time, please state a specific expiration date or event (for example, December 31, 2012, or an event that relates to you personally, such as "until my claim for benefits has been resolved"): _____

_____

_____

II. Important Information About Privacy Rights

I have read and understood the following statements about my privacy rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Carls Center in writing, but the revocation will not have any affect on any actions the Carls Center took in reliance on this authorization before it received my revocation.
- I may request a copy of this authorization.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected under federal privacy laws.
- The Carls Center may not require me to sign this authorization in order for me to receive treatment. But if I do not sign this agreement, the Carls Center will not be able to provide my records to the intended recipients (as listed on page 1 of this document).

III. Signature of Individual

_____ _____

Signature of patient (Or personal representative) Date Relationship if not the patient

If the authorization is being signed by a personal representative of the individual:

_____ _____

Personal Representative's Signature Date

_____

Type/Print Name of Personal Representative

Description of Personal Representative's authority to act for the individual (attach supporting documents): _____

_____