Central Michigan University Health Services

200 Foust Hall, Mt. Pleasant, MI 48859
Phone: (989) 774-3055 Fax (989) 774-4335

Authorization to Release/Obtain Medical Records

I. Information about the records to be disclosed

By signing below, I authorize the Central Michigan University Health Services, including the pharmacy and laboratory operations of UHS, its physicians, pharmacists and employees (collectively, "UHS"), to release or obtain my medical records as described below:

Patient's Name:_____
Last First Middle (Former or maiden if applicable)

Phone #:_____Date of Birth:_____CMU ID#_____

Recipient of Information. My information may be obtained from or disclosed to the following individuals or organizations (include name and address):

From/To: CMU Health Services
(Circle)

From/To: _____
(Circle) Name
_____
Street
_____
City State ZIP Code
_____
Phone #: Fax #:

Information to be released. UHS 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, drug or alcohol dependency or genetic conditions. Unless I have indicated any restrictions below, I am permitting UHS to disclose all of my medical records to the recipient named above. **Restrictions.** Release to the recipient the following records (list restrictions, if any, 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 litigation"), 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 once UHS has obtained or released the requested records. 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 UHS in writing, but the revocation will not have any affect on any actions UHS 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
- UHS may not require me to sign this authorization in order for me to receive treatment. But if I do not sign this agreement, UHS will not be able to provide my records to the intended recipient.

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): _____

_____

For Health Center use only

Completed by:_____ Date completed:_____ Delivery method: ☐ Faxed ☐ Mailed ☐ In Person