Attachment D

# Authorization for Use of Protected Health Information For Uses Other Than Treatment, Payment or Health Care Operations

Client/Patient/Employee Name _____Date:_____
(Please Print Clearly)
Social Security # _____

1. I authorize CMU _____ to disclose the following health information about me:
   - ❑ Audiology/Hearing Reports
   - ❑ Billing Statements
   - ❑ Claims Resolution
   - ❑ Consultations
   - ❑ ECG(s)
   - ❑ Health Services Reports
   - ❑ History & Physical Exam
   - ❑ Immunization Record
   - ❑ Laboratory Reports
   - ❑ Media Release
   - ❑ Pathology Reports
   - ❑ Radiology Reports
   - ❑ Speech-Language Reports
   - ❑ Other:_____

2. The information to be disclosed is PHI from _____ to _____ (dates).

3. This information may be disclosed to (please give name, address and tele. # of recipient):

   _____ _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____

4. This information may be disclosed for the purpose of:
   - ❑ At my request, or
   - ❑ Other: _____

5. The 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.

6. I understand that if the person(s) or entity(ies) that receives 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.

7. I understand that I may inspect or request copies of any information disclosed by this authorization

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8. I understand that I may revoke this authorization by notifying, in writing, CMU _____, except to the extent that action has been taken on it.
9. 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.

_____ _____
Client/Patient/Employee Signature Date

_____
Guardian Signature, if appropriate

_____
Relationship to Client

*(A copy of this signed form shall be given to the client.)*

Revised as of: 4/10/03