WESTERN MICHIGAN UNIVERSITY – UNIFIED CLINICS
1000 Oakland Drive, 3rd Floor, Kalamazoo, MI 49008 (269) 387-7000
AUTHORIZATION TO OBTAIN/RELEASE HEALTH CARE INFORMATION

I authorize WMU Unified Clinics _____ (specify clinic) to
OBTAIN / **RELEASE** (Circle one) the following healthcare information regarding:
_____ Date of Birth: _____
(Print Patient's Name)

Information to be Obtained/Released:

☐ Vision Report(s)
☐ History and Physical
☐ X-Ray films/or reports
☐ Pathology Report(s)
☐ Entire Record
☐ Speech/Language testing/progress notes
☐ Emergency Room Report
☐ Clinical Resume/Discharge Summary
☐ Prenatal Records
☐ Audiology
☐ Operative Report
☐ Consultation(s)
☐ Lab Report(s)
☐ Other (please specify): _____

The following information may be included in the report you are requesting to be released. If one or more of the following apply and you **do not** wish to have the information released, you must place your initials on the appropriate line(s):

_____ Treatment of emotional illness, including documentation by any psychologist or psychiatrist
_____ Treatment of alcohol or substance abuse
_____ Documentation by Social Service personnel
_____ Results of HIV testing; treatment of HIV infection, AIDS or AIDS related complex
_____ Treatment of venereal disease, tuberculosis or communicable disease as specified by Michigan Department of Public Health

Name, Address and Title of person(s) or Organization(s) who we are obtaining/releasing information from/to:

1. _____ 2. _____ 3. _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Purpose of Request: ☐ Individual's Request ☐ Payment (ins. or 3rd party) ☐ Continuing Care

Unless previously revoked, or no expiration date or event is indicated, this consent will expire on year from the date signed below. This authorization may be revoked at any time by notifying the organization in writing at WMU Unified Clinics, HIPAA Privacy Officer, 1000 Oakland Drive, Kalamazoo, MI 49008, but this will not affect disclosures made prior to receipt of the revocation.

I understand that this authorization is voluntary and that any treatment I may seek will not be conditioned upon my signing of this authorization. I understand that if I request a copy of this authorization after it has been signed, one will be provided. Applicable federal and state laws protect information used or disclosed pursuant to this authorization. I understand that the information that is released may be subject to re-disclosure by the recipient and will no longer be protected by these laws.

By signing this authorization, I acknowledge that I have read this form and that I understand its content.

SIGNED _____ **DATE** _____
(Patient or Authorized Representative)

Description of Authorized Representative's Authority to Sign: _____