Sindecuse Health Center
Western Michigan University
1903 West Michigan Avenue
Kalamazoo, MI 49008-5445
269/387-3287 Fax 269/387-4494

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

The HIPAA Privacy Rules (federal regulations that became effective April 14, 2003) provide important protection for health information including that your authorization is obtained in certain circumstances. The Privacy Rules apply to the use and disclosure of Protected Health Information (PHI) by entities providing medical care and treatment.

Name:_____ **WIN:**_____

Birth name:_____ **Date of birth:**_____ **Last visit:**_____

Address:_____

Telephone #:_____

I hereby authorize the release of health information:

From/To: (Circle) Sindecuse Health Center / Western Michigan University

From/To: (Circle)

_____
Name or Organization

_____
Street

_____
City State ZIP Code

Phone/Fax number _____

Specific information needed (indicate date or range to be included):

☐ Alcohol or substance abuse ☐ HIV/AIDS ☐ Lab results ☐Medical notes/summary
☐ Pap & pelvic records ☐ Prescription ☐ Psychiatric records ☐ Psychotherapy/counseling records
☐ X-ray report/images ☐ Other (please specify): _____
Date(s):_____

Purpose for this disclosure:

☐ Continuing care ☐ Insurance ☐ Other (please specify) _____
☐ Marketing (for which SHC ☐will/☐will not receive compensation)

I understand that my personal health information may include health records created or received by providers, including records regarding general medical care; alcohol and substance abuse treatment; psychiatric/psychological treatment; social work counseling; and information regarding communicable diseases and infections, which can include sexually transmitted infections, tuberculosis, HIV, AIDS Related Complex, and claims and billing information. I authorize the release of this information to the individuals or organizations listed above only under the conditions listed below. **This authorization does extend to psychotherapy records but not to psychotherapy notes, as that term is defined in the HIPAA Privacy Rules, 45 C.F.R. § 164.501, to mean notes recorded in any medium by a mental health professional documenting or analyzing the contexts of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's health record.**

If not revoked, this authorization is valid until it expires one year from the date signed below or until the following date or event:_____

I understand that I may revoke this authorization at any time, but I must do so in writing and send to Privacy Officer, Sindecuse Health Center, Western Michigan University, Kalamazoo, MI 49008-5445. The revocation will not be effective to the extent that the Sindecuse Health Center has already disclosed the information. I understand that the information disclosed is subject to re-disclosure and will no longer be protected by the federal Privacy Rules, 45 C.F.R. Parts 160 and 164.

I understand that I have the right to receive a copy of this authorization after it has been signed. A copy or fax of this authorization may be used in lieu of this original.

Patient (or personal representative): _____ **Date:** _____
Signature

_____
Description of personal representative's authority (if any)

FOR HEALTH CENTER USE ONLY

Information: ☐ Mailed ☐ Picked up ☐ Faxed ☐ Other _____ Date needed: _____

Information given/sent by _____ on _____
Name Date

☐ Clinic Visit Records: _____

☐ Counseling Visit Records: _____

☐ Diagnostic summary

☐ EKG _____

☐ Lab _____

☐ Sports Medicine: _____

☐ X-Ray Report: _____ ☐ X-Ray Images _____

☐ Other: _____

☐ ID checked (Bronco ID or verified in EMR)