**WESTERN MICHIGAN UNIVERSITY**
Sindecuse Health Center

1903 W Michigan Ave
Kalamazoo, MI 49008-5445
phone (269) 387-3287
fax (888) 979-8229

# 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.

Your Name:_____ Your WIN:_____

Birth name (if different):_____ Date of birth:_____ Last visit:_____

Address:_____

Telephone #:_____

**I hereby authorize the release of information:**

**FROM TO** (CIRCLE ONE)
**Sindecuse Health Center**
Western Michigan University
Kalamazoo, MI 49008-5445

**FROM TO** (CIRCLE ONE)
**Name or Organization** _____

_____

Street: _____

City :_____State:_____ Zip:_____

Telephone or fax # _____

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

☐ Alcohol or substance abuse ☐ HIV/AIDS ☐ Lab results ☐ Medical notes/summary

☐ Pap & pelvic records ☐ Prescriptions ☐ Psychiatric records ☐ Psychotherapy/counseling records

☐ X-ray report/images ☐ Billing and Insurance info ☐ Other (please specify) _____

Dates: from _____/_____/_____ to _____/_____/_____

## Purpose for this disclosure:

☐ Continuing care ☐ Attorney/Court ☐ 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, 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.

I understand that I may revoke this authorization at any time, but I must do so in writing and send to Medical Records, 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.

**If not revoked, this authorization is valid until it expires one year from the date signed below.** 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) signature** **Date:**

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

## FOR HEALTH CENTER USE ONLY

Records Mailed ☐ Picked Up ☐ Faxed ☐ Other _____ Date Needed _____

Records sent by: _____ on _____
NAME DATE

☐ Clinic Visit r3cords

☐ Counseling Visit Records

☐ Diagnostic Summary

☐ EKG

☐ Lab

☐ Sports Medicine

☐ X-Ray report _____ ☐ X-Ray images _____

☐ Other

☐ ID checked (Bronco ID or verified in EMR )