Counseling & Psychiatric Services (CAPS)
MICHIGAN STATE UNIVERSITY

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (Last, First, MI) _____ **PID#** _____

Address: _____

Date of Birth: _____ **Phone #** _____

I authorize disclosure of protected health information about me as specified below.

FROM _____
Person/entity authorized to disclose this information

_____
Address

_____

_____
Phone/Fax Number

TO: **Counseling and Psychiatric Services (CAPS)**
Person/entity authorized to receive this information
463 East Circle Drive
Address
East Lansing, MI 48824

(517)355-8270/ (517)432-9460
Phone/Fax Number

☐ **Check here** if you are authorizing **reciprocal oral and written exchange** about your health information.
☐ **Check here** if you are authorizing **reciprocal oral consultation** about your health information **only**.
☐ **Check here** if you are **only** authorizing **oral consultation** about your health information from CAPS.

SPECIFY THE INFORMATION TO BE DISCLOSED: You can specify document or time frame

☐ Office Visits _____
☐ Lab Reports _____
☐ X-Ray/CT/MRI _____
☐ Counseling Records _____
☐ Letter _____
☐ Hospital Reports _____
☐ Consultations _____
☐ Info from other health care providers/facilities - specify: _____
☐ Other: _____

I specifically authorize release of information related to the following that may be contained in the above disclosures, if applicable to me:
☒ **Mental Health** ☐ **HIV and Related Diseases** ☐ **Substance Abuse Treatment**

PURPOSE(S) OF THIS DISCLOSURE:
____Continuing Care ____Insurance ____Legal ____Disability _____Workers Comp ____ Patient Request
___Other (specify)___ _____

I UNDERSTAND that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, my health information disclosed here may no longer be protected from further disclosures.

I UNDERSTAND that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.

I UNDERSTAND that I may revoke this Authorization at any time by contacting Olin Health Center, except to the extent that action has already been taken in reliance on this Authorization. Olin Health Center will make no further disclosures to the above person/entity without a new authorization. Olin Health Center can rely on this authorization until it is revoked or expires. This authorization expires: _at termination of treatment_____ (or six months from date signed.)

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient)

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For Staff Use:
☐ ATHENA RECORDS ☐ TITANIUM RECORDS
☐ Process Release – send/request records ☐ Scan Release into patient record, no further action required.

Release form reviewed by:_____

PROVIDE COPY TO PATIENT (IF REQUESTED)