



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 Health Insurance Portability and Accountability Act (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. Complete this form as fully as possible.

Your Identity

Full Name _____ Birth Name (if different) _____

WIN _____ Date of Birth _____

Address: _____

Telephone number _____

I hereby authorize the release of information:

- Send records** from Sindecuse Health Center **to** _____ another provider or _____ myself
- Request records from** another provider for Sindecuse Health Center

Organization Name _____

Street _____ City _____ State _____ Zip _____

Telephone _____ Fax number _____

Specific records or information requested

- Alcohol or substance abuse
- HIV/AIDS
- Lab and X-ray results
- Medical notes or summary
- Pap & pelvic records
- Prescriptions
- Other (please specify) _____
- For Communication purposes only – no records to be sent or received
- Psychiatric records
- Psychotherapy/counseling records
- X-ray images (sent via CD)
- Billing and Insurance Information
- Insurance info

Indicate date or date range to be included:

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.

Signature

Patient (or personal representative) signature _____

Date: _____

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

Return this completed form to Sindecuse Health Center in person, by fax to (888) 979-8229, or attach to a secure message in the patient portal—choose “medical records” as the recipient of your message. You may also mail it to the health center Attn: Medical Records, 1903 W Michigan Ave, Kalamazoo, MI 49008-5445.

Questions? Call (269) 387-3283

.....

For Sindecuse Health Center use only

ID checked (Bronco ID or verified in EMR). Initials: _____