AUTHORIZATION FOR THE DISCLOSURE OF HEALTHCARE INFORMATION

I authorize WMed Health, 1000 Oakland Drive, Kalamazoo, MI 49008
(Name and Address of Physician/Facility)

to disclose the following healthcare information regarding: _____
(Patient's Name - Please Print)

Patient's Date of Birth: _____ Patient's Phone No. (inc. area code): _____

1. **Records relating to visit(s)/date(s)/service(s) of:** _____

2. **Information to be Disclosed:**

☐ Entire Record	☐ X-Ray Films and/or Radiology Reports	☐ Consultations
☐ History & Physical	☐ Immunizations	☐ Inpatient Information
☐ Clinic Notes	☐ Problem List	☐ Emergency Room Reports
☐ Laboratory Reports	☐ Medication Lists	☐ Other: _____

If you do ***NOT*** wish to have the specific information identified below disclosed, you ***MUST*** place your initials on the lines:

_____ Treatment of emotional illness, including documentation by any psychologist or psychiatrist (this **does not** include psychotherapy notes).

_____ 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 sexually transmitted disease, tuberculosis or communicable disease as specified by the Michigan Department of Public Health.

Information is to be disclosed to:

Fax Number: _____

Name of Person/Facility Receiving Information: _____

Address: _____

Purpose of Disclosure (i.e. individual's request, insurance, continuing care, other): _____

This authorization is valid until:

☐ Revoked by the Patient ☐ Expiration Date: _____ ☐ Other: _____

This authorization may be revoked at any time by notifying in writing Western Michigan University Homer Stryker M.D. School of Medicine, Health Information Management, 1000 Oakland Drive, Kalamazoo, MI 49008. 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 this authorization.

Applicable federal and state laws protect information used or disclosed pursuant to this authorization. Information that is released may be subjected to redisclosure by the recipient and will no longer be protected by these laws.

By signing this authorization I acknowledge that I have read it and that I understand it.

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

Description of Authorized Representative's Authority to Sign: _____

WITNESS: _____