NORTHERN MICHIGAN UNIVERSITY

ADA B. VIELMETTI HEALTH CENTER
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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name:_____

DOB:_____ **University IN:** _____

I authorize the Northern Michigan University Health Center to use or disclose the specific health and medical information described below, only for the purposes and parties described below.
Description of the information to be used or disclosed:

____ Specific information to be disclosed _____

____ Any and all of my medical record except the following _____

____ Any and all of my medical information

- Unless specifically excluded, this authorization allows the use and disclosure of information concerning alcohol and other drug dependency or abuse, mental health treatment, infection with HIV or related diseases, and other communicable diseases.

Name and address or FAX# to whom the information is to be disclosed:

_____
_____
_____

Purpose and need for such disclosure:

_____

This authorization shall expire on _____, or six months from date of signature.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting the Health Center at above address
- My revocation is not effective to the extent that the persons I have authorized to use and/or disclose my information have already used or disclosed the information in reliance on this authorization.
- Information used or disclosed to someone who is not required to comply with the federal privacy protection regulations may be re-disclosed by the recipient and would no longer be protected.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or services.
- I understand that in certain instances, e.g.when the Health Center copies and mails records to a life insurance underwriter at my request, the Health Center may receive compensation from a third part for the use or disclosure of my information.

I acknowledge that I have received and understand this authorization.

_____ _____
Patient Signature **Date signed**

_____ _____
Or authorized Patient Representative Signature Date signed

_____ _____
Relationship to Patient Date signed