Oakland University Graham Health Center

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Last Name (Please Print) | First Name (Please Print) | Student ID# (Grizzly #) | Date of Birth

Street Address | City | State | Zip | Phone #

My health information may be used or disclosed by the following persons, class of persons, or departments:

From
Graham Health Center
2200 N Squirrel Rd
To Rochester, MI 48309
Phone (248)370-234
Fax (248)370-2691

From
_____
Name/Organization

To
_____
Address

_____
City State

_____
Phone Fax

I authorize disclosure of the following health information about me in accordance with this authorization.
I understand that my health information may contain information relating to sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, hepatitis, tuberculosis, and treatment for alcohol and drug abuse .

Entire patient record***_____** date range_____

Specific health information _____ date range_____

*Other (please specify)*_____ date range_____

The purpose for the use or disclosure of my health information is: At my request Other: _____
This authorization will expire on: date_____ event _____
Method of Disclosure: Paper_____ CD Format (where available)_____ other_____**
**If you select "Other" and request that your electronic protected health information ("PHI") be transmitted by e-mail or other electronic means, neither the Graham Health Center nor the Oakland University Counseling Center will be responsible for – nor can we guarantee – the privacy or security of any such PHI or transmission. You assume any and all risks and/or liabilities associated with the electronic transmission of PHI initiated at your request.

I understand that I have a right to revoke this authorization at any time, except to the extent that the Health Center has already relied on it. I understand that if I decide to revoke this authorization I must notify the Graham Health Center of my decision in writing (Director Graham Health Center, Oakland University, Rochester Hills MI 48309-4401). I understand that my health information that is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that the Graham Health Center will not condition treatment, or eligibility for benefits on whether I sign this authorization. If, however, health care is provided to me solely for the purpose of creating health information for disclosure to a third party, such health care will only be provided to me if I provide authorization for the disclosure of my health information to that third party.

*PLEASE NOTE GHC CHARGES A FEE FOR COPYING AND/OR MAILING THE ENTIRE MEDICAL RECORD. FEES MUST BE PAID BEFORE RECORDS WILL BE MAILED.

I AUTHORIZE THE GRAHAM HEALTH CENTER TO USE AND DISCLOSE MY HEALTH INFORMATION AS DESCRIBED ABOVE

_____ _____
Signature of Patient | Signature of Personal Representative

_____ _____
Printed Name | Name and Relationship

_____ _____
Date Signed | Date Signed