NORTHERN MICHIGAN UNIVERSITY

HEALTH CENTER
1401 Presque Isle Avenue
Marquette, MI 49855-5301
906-227-2355 | Fax: 906-227-2332
nmu.edu/HealthCenter

PATIENT AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

PATIENT NAME:_____

DOB:_____ **NMU Identification Number:**_____

I hereby consent to the disclosure of information contained in my medical record including if applicable:

- Alcohol and other drug dependency and abuse and mental health treatment information protected under the regulations in Title42 of the Code of Federal Regulation Part II.
- Human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS related complex (ARC) information.

Information to be requested from:

_____

_____

_____

Information to be released to:

Northern Michigan University
1401 Presque Isle Avenue
Marquette MI 49855
FAX# 906-227-2332
Phone# 906-227-2355

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.

PURPOSE and need for such disclosure (i.e. Review of records, Continuity of care)

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_____

I understand that I may revoke this authorization at any time and that this authorization will automatically expire after six months from date of signature.

I have read the above, acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

Patient, Parent or Guardian Signature **Date signed**