ADA B. VIELMETTI HEALTH CENTER
Northern Michigan University
1401 Presque Isle Ave
Marquette, MI 49855-5377
(906) 227-2355 Fax (906) 227-2332

Northern Michigan University

PATIENT AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name: _____

DOB: _____ Medical Record 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 Title 42 of the Code of Federal Regulations Part II.
- Human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS related complex (ARC) information.
- Hepatitis B, sexually transmitted infection, tuberculosis and other communicable disease information.

Information to be requested from:

_____

_____

_____

_____

Information to be released to: **Ada B. Vielmetti Health Center**
Northern Michigan University
1401 Presque Isle Ave.
Marquette, MI 49855
FAX#: 906-227-2332
Phn #: 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 H.I.V. or related diseases, and other communicable diseases.

Purpose and need for such disclosure:

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_____

I understand that I may revoke this authorization at anytime 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**

_____

Witness **Date Signed**