# MONROE COUNTY INTERMEDIATE SCHOOL DISTRICT



1101 S. Raisinville Road

Monroe, Michigan 48161

**734-242-5799 FAX 734-242-5807**

www.monroeisd.us

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**Please print all information clearly:**

Patient Name:       DOB:

Home Address:

I authorize       (physician name)       (contact phone number/fax) to disclose the following protected health information about the above named patient.

**DOCUMENT CONTENTS**

Mental Health Substance Abuse HIV.AIDS Medical

**DOCUMENT TYPES**

Immunization Record  Medication List

Discharge Summary X ray report

X ray film Laboratory results, most recent

Pathology Report Consultations

Entire Record (except for psychotherapy records) from       to

Other (describe)

Send records to:       Address:

Purpose and need for disclosure:

I understand I have the right to revoke this authorization at any time and that I must present such revocation in writing to the authorized party. I understand that a revocation will not apply to information already released under this authorization.

If I fail to specify, this authorization will expire in six months from the date appearing at the bottom of this form. This authorization will expire on the following date, event or condition:      . I understand that this information may be subject to re-disclosure by the recipient and may then no longer be protected. I understand that my treatment, payment, enrollment or eligibility for benefits can not be conditioned upon this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Parent/Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Student Print Name