Minnesota State University Mankato – Student Health Services

21 Carkoski Commons, Mankato, MN 56001 Phone: 507-389-6276 Fax: 507-389-1479

Authorization for Disclosure of Health Information

PLEASE PRINT

Patient Name: ______________________ Date of Birth: __________ Tech ID#: __________

SS#: XXX-XX- ___ ___ ___ ___

I hereby authorize: ❒ Disclose to ❒ Obtain from ❒ Exchange with

Student Health Services
Minnesota State University, Mankato
21 Carkoski Commons
Mankato, MN 56001

____
Facility / Organization

____
Address

____
City / State / Zip Code

PURPOSE OF DISCLOSURE:

❒ Transfer to another clinic
❒ Continued Care
❒ Personal Use
❒ Other ______________________

I specifically authorize the release of information relating to:

❒ Psychological Health
❒ Substance abuse (including alcohol/chemical use)
❒ Sexually transmitted infections
❒ HIV related information (Aids related testing)

______________________ __________
Signature of Patient or Legal Representative Date

SPECIFIC INFORMATION TO BE RELEASED:

❒ Any and all Medical Records
❒ Progress/Provider Notes
❒ X-ray Reports
❒ Laboratory Reports
❒ Allergy Records
❒ Injections/Medications

❒ Records regarding treatment for ______________________
(Specific Condition or Injury)

DATES OF INFORMATION TO BE RELEASED: From _____ / _____ / _____ to _____ / _____ / _____

May information be sent by Fax: ❒ Yes ❒ No
Fax #: (______)__________ ______________________
Signature

Information regarding this authorization:

I understand that each transfer of Medical Records requires a new release form signed by the patient, except the exchange of Counseling/Mental Health Records, wherein the authorization is valid for one year. I understand that I may revoke the authorization at any time and that I will be asked to sign a written statement specifically revoking this authorization. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the recipient of the information. If the recipient is not covered by privacy laws, the recipient could re-disclose the information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A photocopy of this release is valid to the same extent as an original.

______________________ __________ (______) __________
(Signature of Patient or Legal Representative) (Date) (Telephone #)

Sent by __________ Date __________ __________

Note to health care providers: This document complies with the requirements of the Health Insurance Portability and accountability Act of 1996; the Minnesota Government Data Practices Act; and the Minnesota Health Records Act regarding authorization to disclose protected health information. (See 45 CFR 164.508 c)(1) (2002); Minn Stat.Sects 13.05, Subd. 4(d); and 144.335, Subd.3a (2002)

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This document is available in alternative format to individuals with disabilities by calling Student Health Services at 507-389-6276 (V), 711 or 800-627-3529 (MRS/TTY).