AUTHORIZATION TO RELEASE REPRODUCTIVE HEALTHCARE INFORMATION

Patient Name: ________________________________ Previous Name: _____________________________

Date of Birth: _______________ Tech ID: ___________________ Phone: ____________________________

For Reason of Continuing Care, I request and authorize:

- Administration Records of Last Depo Provera Injection (Must include: Date given, site given, lot # Expiration, Date and Nurse Signature)
- Last Annual Exam

Organization Name: ____

Address: __________________________________ City: _________________ State: ______ Zip: _________

Phone: _____________________________________ Fax: ____

To Release Healthcare Information of the patient named above to:

Minnesota State University Mankato, Student Health Services
21 Carkoski Commons
Mankato, MN 56001
Phone: 507-389-6276 **Fax:** 507-389-5787

Definition: Sexually Transmitted Disease (STI) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.
I authorize the release of my STD/STI results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified and that I must give specific written permission before disclosure of these test results to anyone.

____ ______________________

(Signature of Patient or Legal Representative) **(Date)**

Information regarding this authorization:
I understand that each transfer of Medical Records requires a new release form signed by the patient. 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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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. This form can be found at www.mnsu.edu/shs/forms.html.

____ ______________________

(Signature of Patient or Legal Representative) **(Date)**

OFFICE USE: Sent by ___________ Date _______

THIS AUTHORIZATION EXPIRES SIXTY DAYS AFTER IT IS SIGNED. 10/18