# Minnesota State University Mankato – Student Health Services

21 Carkoski Commons, Mankato, MN 56001 • Email: healthservices@mnsu.edu • Phone: 507-389-6276 • Fax: 507-389-5787

## Authorization for Disclosure of Health Information

PLEASE PRINT

Patient Name:_____ Date of Birth:_____ Tech ID#: _____

I hereby authorize:

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

❒ Disclose to ❒ Obtain from ❒ Exchange with

_____
Facility / Organization

_____
Address

_____
City / State / Zip Code

(_____)_____(_____)_____
Phone Number Fax Number

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)

❒ Specific Date Range:: From _____ / _____ / _____ to _____ / _____ / _____

Release Via: ❒ Patient Pickup ❒ Mail ❒ Fax

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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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 #)

Office Use Only

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)