

University of St. Thomas (UST)

Student Health Service & Athletic Department

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

Student/Patient Name: _____

Date of Birth: _____ Student Identification Number: _____

I hereby authorize the use and disclosure of my health information as indicated below. I may revoke this authorization at any time unless records have already been released based on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and may no longer be protected by current Minnesota laws and federal privacy regulations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment at the UST Student Health Service.

I authorize: UST Student Health Service UST Personal Counseling Service
 UST Athletic Department Parent/Guardian
 Other: Name: _____
Address: _____
Phone: _____
Fax: _____

To release the following medical information:

- All my records
- Records related to treatment for _____ of _____ (date)
- Mental Health Records
- Records related to my ability to participate in UST Athletics

For the purpose of:

- Treatment/coordination of care
- Participation in athletics
- Other: _____

To: UST Student Health Service UST Personal Counseling Services
 UST Athletic Department Parent/Guardian
 Other: Name: _____
Address: _____
Phone: _____
Fax: _____

I acknowledge that I received the HIPAA (Health Insurance Portability and Accountability Act) Privacy Practices notice.

Student/Patient Signature: _____

Date of Authorization: _____

(Expires in 1 year unless otherwise directed by student/patient)