



Authorization to Disclose Health Care Information

Student Health Service & Athletic Department
University of St. Thomas
2115 Summit Ave.
Mail Box 5056
St. Paul, Minnesota
Phone: (651) 962-6750
Fax: **(651) 962-6751**

Patient Information

Patient Name (please print) _____ Date of Birth _____

Address, City, State, Zip: _____

Phone () _____ Cell Phone () _____

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH CARE INFORMATION AS INDICATED:

Release Information From:

Send My Information To:

Method for sending information: Mail Hold for Pick up Fax Date needed: _____

Medical Information requested to be sent:

- Complete Record(s)
- Lab(s) / X-Ray Reports
- GYN / Pap
- Immunization
- Physical Exam
- Other _____

Reason for Release:

- To update my regular doctor (provider)
- I have been referred to another doctor
- I am moving/ graduating
- Talk with Parent / Guardian
- Other _____

Fax records to: 651-962-6751

By: Date _____

Specific Authorization for Release of Information Protected by State of Federal Law

Note: You MUST mark Yes or No

I specifically authorize the release of data and information relating to:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Substance Abuse (alcohol / drug abuse) |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Mental Health (ADD, depression, anxiety testing) |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. HIV – related information (AIDS related testing) |

Federal and/or State law specifically require that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS – related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or an otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I UNDERSTAND THAT:

- This authorization will automatically expire one year from the date of my signature or on ____/____/____
- This authorization may be revoked at any time by notifying Student Health Service or the Athletics Department in writing except to the extent that action has been taken in reliance on it.
- I can request an accounting of disclosed information by writing to the University of St. Thomas, Student Health Service
- My refusal to sign or revocation of, this authorization will not affect my ability to obtain health care services from the University of St. Thomas Student Health Service.
- The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by Federal of State privacy rules.

Signature of patient or legal guardian (students over 18 must sign own release)

Date

Relationship if not the patient