Center for Well-Being | UNIVERSITY OF St.Thomas

Phone: **(651) 962-6750**
Fax: **(651) 962-6751**

Authorization for the Release of Information

Name: _____

Date of Birth *(mm/dd/yyyy)*: _____ University of St. Thomas ID#: _____

RELEASE INFORMATION **FROM**:

☐ **Center for Well-Being**
☐ **Other** (specify practice, organization, department, or individual)

Complete each line below:

Person / Practice: _____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

Additional info (optional): _____

_____

RELEASE INFORMATION **TO**:

☐ **Athletics**
☐ **Center for Well-Being | FAX: (651) 962-6751**
☐ **Dean of Students / Residence Life**
☐ **Disability Resources / Academic Counseling**
☐ **Office of International Students & Scholars (OISS)**
☐ **Self**
☐ **Sports Medicine / Twin Cities Orthopedic**
☐ **Other** (specify organization, department, or individual below)

Person / Practice: _____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

DELIVERY OF INFORMATION:

Preferred method, check all that apply:

☐ Written copy (may include completed forms) ☐ Verbal ☐ Both *Date information is needed:* _____

Written information will be faxed, unless an alternate method is checked: ☐ Mailed ☐ Secure Email (Liquid Files)

RECORDS OR REPORTS TO BE RELEASED:

TIMEFRAME (Dates) to be released. Check One:

☐ From: _____ To: _____ ☐ All dates of service.

☐ Present: _____ Date: _____ ☐ Present and continuing until this form expires or is revoked.

☐ Completion of a form/letter (please attach form)
☐ Complete Health Services / Medical Record, **OR**
☐ Specific Medical Information (check all that apply):
  ☐ Lab reports
  ☐ X-ray/Radiology reports
  ☐ Physical Exam
  ☐ Immunization(s)
  ☐ Medication(s)
  ☐ Sexual Assault Nurse Examination

☐ Case Management / Care Coordination
☐ Wellness Coaching
☐ Complete Counseling records, **OR**
☐ Specific Counseling Information:
  ☐ Counseling Attendance
  ☐ Progress notes
  ☐ Psychological Assessment / Testing
☐ Other _____

SPECIFIC AUTHORIZATION FOR THE RELEASE OF INFORMATION PROTECTED BY STATE/FEDERAL LAW:

These records require specific consent for release. *I specifically authorize the release of data and information relating to:*

☐ 1) Chemical dependency program ☐ 2) Psychotherapy notes ☐ 3) HIV related information (AIDS related testing)

SIGNATURE AND DATA:

I understand that:

- This authorization will automatically expire one (1) year from the date of my signature **OR** on: _____
- I can contact the **Center for Well-Being** at **(651) 962-6750** to revoke this authorization at any time.
- My refusal to sign, or revocation of this authorization will not affect my ability to obtain services from the Center for Well-Being
- I understand that once information is released to an outside party pursuant to this authorization, the Center for Well-Being cannot prevent the re-disclosure of the information to another third party.
- I have a right to inspect and receive a copy of the material to be disclosed, and a copy of this release.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situations may require a minor's authorization.

▶ Signature ***(required)***: _____ Date of Authorization: _____

Printed Name of Person Signing **IF NOT PATIENT:** _____ ***Reason patient cannot sign:*** ☐ Minor ☐ Incapacitated ☐ Deceased

Relationship IF NOT PATIENT (legal documentation of the right of access by the signing individual may be required):

☐ Parent ☐ Step-parent ☐ Legal Guardian ☐ Foster Parent ☐ Healthcare Power of Attorney ☐ Other _____