

Mailing address:  
University of St. Thomas  
Health Services  
2115 Summit Avenue, Mail# 5056  
St. Paul, MN 55105



# HEALTH SERVICES

Fax: **651-962-6751**  
Office: 651-962-6750  
Email: healthservices@stthomas.edu

## Authorization for the Release of Health Information

### PATIENT INFORMATION:

Name (please print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

UST ID#: \_\_\_\_\_ Phone (Cell): \_\_\_\_\_ Other: \_\_\_\_\_

*I hereby authorize the release of my health information:*

#### FROM:

University of St. Thomas Health Services

2115 Summit Avenue, Mail 5056 | St. Paul, MN 55105

Office: 651-962-6750 | Fax: 651-962-6751

#### SEND INFORMATION TO: Clinic / Person / Phone / Fax:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Method for sending information:  FAX  EMAIL  HOLD FOR PICKUP  MAIL Date Needed: \_\_\_\_\_

#### Medical Information Requested:

- Complete Record(s)
- Lab(s) / X-ray Reports
- GYN / Pap
- Immunization
- Physical Exam
- Other \_\_\_\_\_

#### Reason for Release:

- To update regular doctor / provider
- Referred to another doctor / provider
- Moving / graduating
- Communication with parent / guardian
- Physical Exam
- Other \_\_\_\_\_

Method of communication authorized:  VERBAL  PRINTED COPIES OF RECORDS  LETTER / FORM COMPLETION

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

#### You **MUST** mark **YES** or **NO**:

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

- |   | <b>YES</b>               | <b>NO</b>                |
|---|--------------------------|--------------------------|
| 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) | <input type="checkbox"/> | <input type="checkbox"/> |

Federal and/or State law specifically requires 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 CFR 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 Health Services 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 Health Services clinic.
- 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 Health Services clinic.
- The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State privacy rules.

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

Date

Relationship, if not the patient

Date Faxed: \_\_\_\_\_