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

UNIVERSITY OF St. Thomas

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: Clinic / Address / Phone / Fax:

_____

_____

_____

SEND TO:

University of St. Thomas Health Services

Fax: **651-962-6751**

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

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:

	YES	NO
1. Substance Abuse (alcohol / drug abuse)	❑	❑
2. Mental Health (ADD, depression, anxiety testing)	❑	❑
3. HIV – related information (AIDS related testing)	❑	❑

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 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 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: _____