CONSENT TO RELEASE HEALTH INFORMATION

PATIENT INFORMATION:

First name________________________Middle______________Last Name__________________

Address____

City______________________________State__________Zip Code______________

Patient Date of Birth_____/_____/_______Mustang ID Number______________Phone (_____)____________

I AUTHORIZE SMSU STUDENT HEALTH SERVICES TO: ☐ **RELEASE INFORMATION TO AND/OR** ☐ **RECEIVE INFORMATION FROM**

Southwest Minnesota State University Health Services | 1501 State Street, Marshall, MN 56258
Telephone (507) 537-7202 | Fax (507) 537-7259

Name of facility/person____

Address____

City______________________________State__________Zip Code______________

Fax (_____)______________________________Phone (_____)__________________________

INFORMATION TO BE RELEASED

IMPORTANT: Indicate only the information authorized to be released.

Specific dates/years of treatment____

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History & Physical ☐ Progress notes dated ☐ Psychotherapy notes ☐ Depo Provera information
☐ Mantoux(TB) Screening ☐ Laboratory reports dated ☐ Chemical dependency program
☐ Other information or instructions____

Health Information includes any information about you related to mental health evaluation and treatment, concerns about drugs and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases, and genetic information.

REASONS FOR RELEASING INFORMATION

☐ Patient's request/Personal ☐ Legal ☐ Treatment/continued care
☐ Review patient's current care ☐ Insurance ☐ Other (please explain)______________________

I understand that by signing this form, I am requesting that the health information specified above be sent to the party named above. I may revoke this consent at any time by writing to the facility that was named to release the information. If this facility has already released health information based on my consent, my request to revoke will not pertain to the health information already released. I understand that when the health information specified is sent to the party named above, the information could be re-disclosed by the party that receives it and may no longer be protected by federal or state privacy laws. I understand that I may refuse to sign this consent and that my refusal to sign will not affect treatment, payment, enrollment or eligibility for benefits. If I choose not to sign this form and the facility that the information is to be released to is an insurance company, I may not be able to get new or different insurance, and/or I may not be able to get insurance payments for my care.

This consent will end one year from the date the form is signed unless I indicate an event or earlier date here:

Specific event____OR Date_____/_____/______
MM DD YYYY

Patient's Signature______________________________________Date_____/_____/________

For Internal Use Only: Date Reviewed____________________By____________________

Date Released____________________By____________________ ☐ Mailed ☐ Faxed ☐ Picked up by patient

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