

**CONSENT FORM TO RELEASE HEALTH INFORMATION**

**PATIENT INFORMATION**

First name \_\_\_\_\_ Middle name \_\_\_\_\_ Last name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Patient date of birth \_\_\_/\_\_\_/\_\_\_\_\_ Student ID number \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

I AM REQUESTING HEALTH INFORMATION TO BE RELEASED  **FROM**       **TO** (Must check one)

**St. Cloud State University Student Health Services**  
**720 Fourth Avenue South, St. Cloud, MN 56301-4498**  
Telephone: **(320)308-3193**  
Fax: **(320)308-3192**

I AM REQUESTING THAT HEALTH INFORMATION BE RELEASED  **FROM**       **TO** (Must check one)

**Self (at above address)**

Name of facility/person \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Fax (\_\_\_\_\_) \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

**INFORMATION TO BE RELEASED**

**IMPORTANT: Indicate only the information that you are authorizing to be released.**

Specific dates/years of treatment \_\_\_\_\_

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Immunizations                           | <input type="checkbox"/> All UTI's and/or URI's    | <input type="checkbox"/> Progress notes dated _____     |
| <input type="checkbox"/> Mantoux screening                       | <input type="checkbox"/> All Laboratory reports    | <input type="checkbox"/> Laboratory reports dated _____ |
| <input type="checkbox"/> Radiology report                        | <input type="checkbox"/> Annual Gynecological Exam | <input type="checkbox"/> Depo Provera record            |
| <input type="checkbox"/> 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.

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

Psychotherapy notes

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

**REASON(S) FOR RELEASING INFORMATION**

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> Patient's request             | <input type="checkbox"/> Legal     | <input type="checkbox"/> Treatment/continued care     |
| <input type="checkbox"/> Review patient's current care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (please explain) _____ |

I understand that by signing this form, I am requesting that the health information specified above be sent to the third party named above. I may stop 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 stop will not work for the health information already released.

I understand that when the health information specified is sent to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the facility that the information is released to is a health care provider, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the facility that the information is to be released to is an insurance company, my failure to sign will not impact my treatment; however, I may not be able to get new or different insurance, and/or I may not be able to get insurance payment 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