MEDICAL CLINIC AND COUNSELING AND PSYCHOLOGICAL SERVICES
ST. CLOUD STATE UNIVERSITY

Internal Consent Form to Release Health Information

Student/Patient Information	Full Name: _____ Student ID: _____ Phone Number_____ Date Of Birth (mm/dd/yyyy): _____ Address: _____ City: _____ State: _____ Zip Code: _____
I Authorize	**St Cloud State University Medical Clinic and Counseling and Psychological Services (CAPS)** 720 Fourth Ave South, St. Cloud, MN 56301 Phone: 320-308-3191 or 320-308-3171 Fax: 320-308-3192 or 833-434-1362 to do the following: ☐Release To ☐Receive From ☐Both Release and Receive with
The following	☐Academic Affairs ☐Academic Appeals and Probation ☐Advising and Student Transitions ☐All Faculty of Enrolled Courses ☐Business Services ☐Center for International Studies ☐College of Health and Wellness Professional Practicum Training Clinic ☐Division of Student Affairs ☐Athletics ☐Husky ACT ☐Husky PAW ☐Office of Equity and Access/Title IX ☐Office of Records and Registration (Registrar) ☐Public Safety ☐Residential Life ☐Student Accessibility Services ☐Student Registration and Financial Services (Financial Aid) ☐ Other_____
What is to be released	☐All Verbal/All Coordination ☐All Health Care Records ☐All Medical Clinic Records ☐All CAPS Records ☐ Provider Letters/Medical Verification Forms ☐Labs ☐Most Recent Hospitalization and Discharge Paperwork ☐All Progress Notes and Treatment Plans ☐Records Related to the Following Condition: _____ ☐Date(s) of service: From: _____ To:_____ Other: _____
Purpose of Release	☐Patient Request ☐Coordination of Care ☐Legal ☐Treatment/Continued Care ☐Insurance ☐Review Patient's Current Care ☐Other_____
Disclaimers	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.
Authorization	This authorization will expire one year from the date of the signature below unless there is a different date/event indicated below. You can indicate a different date or event here to shorten or extend the release (144.293, Subd. 4) from the date of the authorized signature below: _____ Patient Signature: _____ Date: _____
For Office Use Only	Staff Initials: _____ For Office Support: ☐Scan In ☐Requesting Records ☐ Releasing Records Completed by: _____ Date: _____ ☐Mailed ☐Faxed ☐ Picked up by patient ☐Portal