

CONSENT FORM TO RELEASE HEALTH INFORMATION

PATIENT INFORMATION

First name _____ Middle name _____ Last name _____

Patient date of birth / / Student ID number _____ Phone (____) _____

Address _____

City _____ State _____ Zip code _____

I AUTHORIZE MY HEALTH INFORMATION BE RELEASED FROM TO (Must check one)

St. Cloud State University Medical Clinic and/or Counseling & Psychological Services (CAPS)

Provider (optional) _____

720 Fourth Avenue South, St. Cloud, MN 56301-4498

Medical Clinic Phone: 320-308-3191

CAPS Phone: 320-308-3171

Medical Clinic Fax: 320-308-3192

CAPS Fax: 320-308-0959

I AUTHORIZE MY HEALTH INFORMATION BE RELEASED FROM TO (Must check one)

Self (at above address)

Name of facility/person _____

Address _____

City _____ State _____ Zip code _____

Telephone (____) _____ Fax (____) _____

I request my health information be faxed to: Fax (____) _____

I AUTHORIZE MEDICAL/COUNSELING STAFF TO DISCUSS, SHARE AND/OR EXCHANGE MY HEALTH INFORMATION AS STATED BELOW WITH THE PERSON(S) HERE _____

HEALTH INFORMATION TO BE RELEASED

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

All health information from Medical Clinic records

All health information from Counseling and Psychological Services records

Health Information from (specify dates or treatment) _____

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.

REASON(S) FOR RELEASING INFORMATION

Patient's request

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 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 ____/____/____

Patient's signature _____ **Date** _____

For Internal Use Only: Date Reviewed _____ By _____ Mailed Faxed Picked up by patient
Date Released _____ By _____ Disclosure
Date Release Form Reviewed _____ By _____ Mailed Faxed