

**CONSENT FORM TO RELEASE HEALTH INFORMATION – (INTERNAL)**

**PATIENT INFORMATION**

First name \_\_\_\_\_ Middle name \_\_\_\_\_ Last name \_\_\_\_\_

Patient date of birth mm dd yyyy Student ID number \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

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

Self (at above address)

Multicultural Student Services (308.3003)

Academic Affairs (308.3143)

Residential Life (308.2166)

Academic Appeals (308.2111)

Center for International Studies (308.4287)

Student Accessibility Services (308.4080)

Student Life and Development (308.3111)

Women's Center (308.4958)

Financial Aid (308.2047)

Public Safety (308.3453)

Faculty/Staff: \_\_\_\_\_

Behavioral Intervention Team (BIT)

I request my health information be faxed to: Fax (\_\_\_\_\_) \_\_\_\_\_

**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