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

St. Cloud State University Student Health Services Provider (optional)_____

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

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 (_____)_____

☐ Other _____

☐ **I AUTHORIZE HEALTH SERVICES 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 included in my record

☐ 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.

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

☐ 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 _____

Date Released _____By _____ ☐ Mailed ☐ Faxed ☐ Picked up by patient

Date Release Form Reviewed_____ By_____ ☐ Mailed ☐ Faxed