CONSENT FORM TO RELEASE HEALTH INFORMATION

PATIENT INFORMATION

First name_____ Middle name_____ Last name_____

Patient date of birth ___/___/_____ Student ID number _____Phone (_____)_____
mm dd yyyy

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