



Minot State UNIVERSITY

Minot State University - Student Health Service
500 University Ave W Minot, ND 58707 Phone: (701) 858-3371 Fax: (701) 858-3997

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

First record request is free, additional record requests are \$20

PLEASE PRINT, COMPLETE and UPLOAD. *See instructions below on how to upload
IF YOU ARE AN ALUMNI OR NOT A CURRENT STUDENT, PLEASE FAX OR EMAIL THE COMPLETED FORM TO
701-858-3997 OR Michelle.Sayler@minotsteu.edu.

Patient Name Last (Previous Name) First MI

Date of Birth mm dd year Student ID# Phone ()

1. I HEREBY AUTHORIZE MSU STUDENT HEALTH SERVICE TO: (check appropriate box)

- Release to: Receive from: Release to self:

* If releasing records to self, how do you want to receive them? Mail I will pick them up at Student Health

Name

Address Phone ()

City/State/Zip Fax ()

2. INFORMATION TO BE RELEASED: (check all applicable)

- Progress Notes Lab Report(s) GYN Report(s) TB Reports
Immunization(s) Other:

3. RECORDS FROM THE TIME: mm dd year through mm dd year

4. PURPOSE OF DISCLOSURE: (check applicable purpose)

- Continued Medical Care Legal Personal Insurance purposes New school Other

- 5. I understand this authorization shall be valid for one year after which time it will automatically expire without my express revocation.
6. I understand I have the right to revoke this authorization, in writing, at any time except to the extent that action has already been taken.
7. I understand the information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
8. MSU Student Health Service will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
9. A photocopy of this authorization will be treated in the same manner as the original.

X Signature of Patient or Patient Representative Date mm dd year

If signature by other than patient, state authority and relationship Date mm dd year

Special Authorization: Check all applicable box(es) and sign below. By signing below, I am authorizing MSU Student Health Service to release any and all information regarding:
Alcohol Drugs Mental Health Sexually Transmitted Diseases HIV/Hep C AIDS
Note: If this release pertains to alcohol, drug or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Patient Signature Date mm dd year Patient's Signature

Upload this form to the MSU Student Health Portal at https://minotsu.medicatconnect.com/login.aspx IF YOU ARE AN ALUMNI OR NOT A CURRENT STUDENT, PLEASE FAX OR EMAIL THE COMPLETED FORM TO 701-858-3997 OR Michelle.Sayler@minotsteu.edu.

- 1. Use your campus connection username and password to log in
2. Choose upload
3. Choose document type you are uploading
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