Minot State UNIVERSITY

Student Health Center
500 University Ave. W., Lura Manor, Minot, ND 58707
Phone: (701) 858-3371 • FAX: (701) 858-3997

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Name of Student (Last, First, Middle Initial) | Student I.D. Number | Birthdate

Street Address | City | State | Zip Code

SPECIFIC INFORMATION TO BE DISCLOSED:

Covering the period(s) of healthcare from (date) _____ to (date)_____(1 year unless specified)

- ❑ Progress Notes
- ❑ History & Physical
- ❑ Pap/Pelvic Reports
- ❑ Lab Reports
- ❑ X-Ray Reports
- ❑ X-Ray Films
- ❑ Immunizations
- ❑ Consultation Report(s)
- ❑ Other, please specify_____

PURPOSE OF THE DISCLOSURE: *(Please specify)*_____

I, Authorize:

_____
_____
_____

To release to:

MSU Student Health Services
500 University Avenue, Lura Manor
Minot, ND 58707

Check how you prefer your health information be communicated: ❑ Send by mail ❑ *Send by facsimile ❑ Hand Carry

*Fax# ( ) _____-_____(Facsimile transmission of medical records is discouraged and should only be utilized when mailing would not meet the immediate needs of the patient. Student Health Services will disclose medical information by facsimile transmission with the patients understanding and written consent that this type of communication does not ensure confidentiality.

Please initial the following statement after reviewing: _____ I have read the previous statement regarding facsimile transmission and give Student Health permission to send my authorization for disclosure of my medical records by facsimile transmission.

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above.

I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand the MSU Student Health Services may not condition my treatment or payment of my bills on my decision to sign this authorization.

A photo copy is valid as the original record.

PATIENT SIGNATURE: _____ **DATE:** _____

This authorization shall be in effect for 12 months following the date of the signature.

SHS OFFICE USE ONLY:

Date Record(s) Sent: _____ Signature of Sender: _____