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 FAX TO 701-858-3997

Patient Name _____ / _____ / _____
Last (Previous Name) First MI

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

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:** _____ /_____ /_____ through _____ /_____ /_____
   mm dd year 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 _____ Date _____ /_____ /_____
Signature of Patient or Patient Representative mm dd year

_____ Date _____ /_____ /_____
If signature by other than patient, state authority and relationship 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 _____ /_____ /_____ Patient's Signature
mm dd year

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Allow 7-10 business days.