

## Student Center for Health and Counseling

### AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name	Previous Names	Student ID#
--------------	----------------	-------------

Address	Social Security #	Birthdate
---------	-------------------	-----------

Phone Numbers		
Home:	Work:	Other:

**This will authorize:**

Name/Organization: Bemidji State University Student Center for Health and Counseling Phone: 218-755-2053; 755-2024

Fax: 218-755-2750

Street Address: 1500 Birchmont Dr. NE - #30

Bemidji, MN 56601

           **To Release Records or Information To:**                 **To Request Records or Information From:**      (please check)

Name/Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**The following information is to be released (Optional, modify as needed):**

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology Reports (including pap)	<input type="checkbox"/> Client/Diag. Assess.
<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> X-Ray/Radiology Reports	<input type="checkbox"/> Conduct Ref. Info.
<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Alcohol/CD Records
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> EKG/ECHO Reports	<input type="checkbox"/> Psych. Eval. or Test Interpretation
<input type="checkbox"/> Emergency Services Reports	<input type="checkbox"/> Family/Social History	<input type="checkbox"/> Other (specify) _____

**For the following date(s) of treatment or condition:** \_\_\_\_\_  
(specify dates of treatment or condition)

**I am requesting this information be released for the following purpose:**

<input type="checkbox"/> Cont'd. Care by Another Provider	<input type="checkbox"/> Insurance Claim Process	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Attorney Review	<input type="checkbox"/> Coordination of Services/Care	<input type="checkbox"/> Other: _____

- All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here: \_\_\_\_\_
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or (period of time, i.e., 2 days, 3 weeks, 5 months) from the date of my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Minnesota Statute 144.335 3a; for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigation or quality of care; for release to an external researcher solely for purposes of medical or scientific research. As noted above, I understand I may revoke this authorization by written request at any time to address listed above.
- I understand there may be a retrieval and copy charge associated with the release.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the BSU Student Center for Health and Counseling at the address above.
- I understand this authorization must be filled out completely, signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.

\_\_\_\_\_  
Signature of Student/Authorized Person

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date