Bemidji State University
Student Center for Health and Counseling
Authorization for Release of Information

Please fill out this form completely; incomplete forms are invalid and will not be processed.

Name: _____ ***Student ID# :*** _____ ***Birthdate:*** _____
Last *First* *Initial*

Address: _____ ***Phone Number:*** _____

This will authorize:
Name/Organization: Bemidji State University Student Center for Health & Counseling **Phone:** 218-755-2053___

Address: 1500 Birchmont Drive NE #42 Bemidji, MN 56601 **Fax:** 218-755-2750 **Email**: healthservices@bemidjistate.edu

Choose from the options below: **Via:**

Release Records To ____ Request Records From ____ **Mail ___ Fax ____ Pick Up ____**

Name/Organization: _____

Street Address: _____ Phone #: _____ Fax #: _____

City: _____ State: _____ Zip: _____

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

_____ Discharge Summary	_____ Pathology Reports (including pap)	_____ Client/Diagnostic Assessment
_____ Clinic Notes	_____ X-Ray/Radiology Reports	_____ Conduct Referral. Info.
_____ History & Physical Exam	_____ Lab Reports	_____ Alcohol/CD Records
_____ Consultation Reports	_____ EKG/ECHO Reports	_____ Psych. Eval. or Test Interpretation
_____ Emergency Services Reports	_____ Family/Social History	_____ Medications
_____ Immunizations	_____ Care Plan	_____ Billing records

_____ Other: _____

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:

_____ Cont'd. Care by Another Provider	_____ Insurance Claim Process	_____ Patient's request
_____ Attorney Review	_____ Coordination of Services/Care	_____ Payment

_____ Other: _____

The following information requires special consent by law. Even if you indicate **all health information,** you must specifically request the following information in order for it to be released:

- **_____Chemical dependency program**
  _____Psychotherapy notes (this consent cannot be combined with any other consent.
- 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 re-disclosure, 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

Records Released Via: Mail ___ Fax____ Pick Up___