MINNESOTA STATE UNIVERSITY moorhead

Authorization to Disclose Protected Health Information

Hendrix Health Center

Name ____ SS # ____________________ Birth date __________
Last First M.I.

Note: You are not legally required to provide your Social Security number, but if you do so, it will be used by provider staff to process this release and ensure the identity of the records. Failure to provide this number may result in delay or misidentification.

Recent Name Change ____ MSUM ID# ____________________________

Street Address: ____

City: ____ State: _______________ Zip Code: __________

Recent Name Change: (Maiden Name or Previous Married Name) ____

I authorize: ______________________________________ to release to: ____________________________________

______________________________________ ____________________________________

______________________________________ ____________________________________

Type or extent of information to be disclosed (check all applicable categories):

- ❑ Entire Medical Record
- ❑ Records pertaining to care for the period beginning _______________ and ending ______________________________
- ❑ Other (please specify) ____
- ❑ Psychiatric/Psychological/Counseling
- ❑ HIV/HIV related illness
- ❑ Chemical Dependency treatment

Purpose or need for disclosure or protected health information:

❑ Further treatment ❑ Other (please specify) ____

Date of expiration for this authorization is __________ or, 1 (one) year if not otherwise specified and for 2 (two) years for financial transactions.

- ❑ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, your insurance company may deny a service that they request (e.g., physical exam) if your authorization is not given.
- ❑ I understand that I may request a copy of this signed authorization. A photocopy of this release is valid to the same extent as an original
- ❑ I understand that my information may or may not be protected from re-disclosure by the recipient of the information. If the recipient is not covered by privacy laws, the recipient could re-disclose the information.

Notice to recipients of information disclosed from alcohol or drug abuse treatment records protected by Federal confidentiality rules (42 CFR part 2). T): The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly 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.

Note to health care providers: This document complies with the requirements of the Health Insurance Portability and Accountability Act of 1996; the Minnesota Government Data Practices Act; and the Minnesota Health Records Act regarding authorizations to disclose protected health information. See 45 CFR 164.508c (1) (2002); MN State Sects 13.05, Subd. 4(d); and 144.335. Subd. 3(a) (2002).

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS IN ACCORDANCE WITH THE SPECIFICATIONS LISTED ABOVE.

Signature of Patient : ____ Date: _______________

(Personal or legal representative) I represent and warrant that I am the Personal Representative or otherwise legally authorized to act for the Client/Patient named above and am signing this authorization in such capacity.

Signature of Personal Representative: ____ Date: _______________

(Description of relationship or legal authority) ____

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Authorization to Fax Medical Records

AUTHORIZATION AND REQUEST FOR TRANSFER OF MEDICAL INFORMATION BY FACSIMILE (FAX):

FROM: Hendrix Health Center
Minnesota State University Moorhead
P.O. Box 92
Moorhead, MN 56563
FAX: 218.477.5867

TO: ____

____

____

I authorize the transfer of medical records in accordance with the specifications listed above and specified on the reverse of this form.

I authorize the transfer of medical records in accordance with the specifications listed above and specified on the reverse of this form.

Signature of Patient: ____ Date: ______________________

(Personal or legal representative) I represent and warrant that I am the Personal Representative or otherwise legally authorized to act for the Client/Patient named above and am signing this authorization in such capacity.

Signature of Personal Representative: ________________________________ Date: ______________________

(Description of relationship or legal authority) ____

I understand that I may revoke this authorization at any time and that I will be asked to sign the <u>Revocation Request</u> below.

REVOCATION REQUEST

I hereby request that this authorization to disclose health information of ______________________________________

signed by ________________________________ on ______________ be rescinded, effective ______________.

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Patient: ____ Date: ______________________

(Personal or legal representative) I represent and warrant that I am the Personal Representative or otherwise legally authorized to act for the Client/Patient named above and am signing this authorization in such capacity.

Signature of Personal Representative: ________________________________ Date: ______________________

(Description of relationship or legal authority) ____