

**Authorization for the Use or Disclosure of  
Protected Health Information**

**Missouri S&T Health Center**  
910 W 10th St  
Rolla, Mo. 65409

**Record Release Numbers**  
Phone (573) 341-4284  
Fax (573) 341-6967

**As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purpose other than treatment, payment or health care operations. In our Notice of Privacy Practices, we provided you information about how the Missouri S&T Health Center can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Authorization.**

\_\_\_\_\_  
(Patient Name – First, Middle, Maiden, Last)

\_\_\_\_\_  
(Student Number)

(\_\_\_\_\_) \_\_\_\_\_

(Phone Number including area code)

(Student ID)

(Date of Birth)

**I authorize the Missouri S&T Health Center to:**

Please check one of the following:

**Obtain protected health information from the following location via (check one):**

phone,  mail, or  fax

**Release my Student Health Center protected health information to the following via (check one):**

phone,  mail, or  fax

\_\_\_\_\_  
(Name of Authorized Person, Agent or Physician)

\_\_\_\_\_  
(Phone Number including area code)

\_\_\_\_\_  
(Company, Hospital or Practice)

\_\_\_\_\_  
(Fax Number including area code)

\_\_\_\_\_  
(Address/Street)

\_\_\_\_\_  
(City/State/Zip)

If applicable, indicate date of clinic appointment when these records will be needed.

**The following information from my medical records:**

Clinical Progress Notes \_\_\_ including \_\_\_ excluding primary care behavioral health

History and Physical

Women's Health visit(s) including pap results

Laboratory Reports (specify which lab tests): \_\_\_\_\_

Other \_\_\_\_\_

PPD testing, Chest x-ray and treatment records

Immunizations

Titters

Dates of treatment to be released: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Specific purpose of request (how info will be used) \_\_\_\_\_

**See Reverse Side**

**Office Use Only**

\*501\*

Release Complete: # Pages \_\_\_\_\_  
Faxed \_\_\_\_\_ Picked Up \_\_\_\_\_  
US Mail \_\_\_\_\_ Campus Mail \_\_\_\_\_  
By \_\_\_\_\_ Date \_\_\_\_\_

Per Federal regulation 42 CFR Part 2 and MSMO 191-656 a specific authorization is required to release “sensitive” information. If such information is contained in a patient’s record, that information will not be released unless specifically authorized below.

<u>Specific data authorized for release</u>	<u>Patient Initials</u>	<u>Date</u>	<u>Provider Initials</u>
HIV Testing and Results	_____	_____	_____
Substance Use Intervention Notes	_____	_____	_____
Behavioral Health Counseling Notes	_____	_____	_____

**Check one:**  **yes**  **no**  I understand that if the protected health information being disclosed herein *contains information regarding drug and/or alcohol abuse, psychiatric/psychological care, sexually transmitted infections, including AIDS, and Hepatitis B or C testing or results*, I agree to their release.

- Unless you revoke this Authorization in writing, this Authorization will expire 6 months from the date it was signed or upon expiration of the event for which the authorization was requested.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person or entity having received it, and may no longer be protected by federal or state privacy regulations or laws.
- I understand that my treatment or care from the Student Health Center is not conditioned on my signing this authorization and that I will not be denied medical treatment or care if I do not sign this authorization. I also understand that I can inspect or copy the protected health information to be used or disclosed pursuant to this authorization.
- I understand that this authorization may be revoked by me at any time, by notifying in writing the Student Health Center directed to: Medical Director, S&T Student Health Center, 910 W 10th St, Rolla, MO 65201. I understand that any use or disclosure of the protected health information pursuant to this authorization prior to the effective date of the revocation will not be affected by the revocation.
- I understand that a photocopy or facsimile copy of the authorization will be as valid as the original. I am entitled to receive a copy of this authorization.
- Student Health may assess appropriate and reasonable fees for copying such information. Such fees will comply with all state and federal laws. .

Date: \_\_\_\_\_ By: \_\_\_\_\_  
Signature of Patient / Legal Representative

Please allow 5-7 working days to process your request