Authorization for the Use or Disclosure of Protected Health Information

Missouri University of Science & Technology
Student Health Services
910 W 10th St
Rolla, MO 65409

Record Release Numbers
Phone: (573) 341-4284
Fax: (573) 341-6967
Email: mstshs@mst.edu

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 ID Number)

(________)______________________ ______________________
(Phone Number including area code) (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)

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
❑ Titers

Dates of treatment to be released: _______/______/_____ to ______/_____/_____

Specific purpose of request (how info will be used) ____

See Reverse Side

Office Use Only

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.

Specific data authorized for release	Patient Initials	Date	Provider Initials
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 65409. 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 3-5 business days to process your request