

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

Missouri S&T Student 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 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

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 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 5-7 working days to process your request