Missouri S&T Student Health Center
910 W 10th Street Rolla, MO 65409
Phone (573) 341-4284
Fax (573) 341-6967
Email: mstshs@mst.edu

(Complete field or place patient label here)
Name
DOB
Student ID

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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.

1. Additional Patient Information

Patient Name*: First, Middle, Last*	Previous or Maiden Name *(if applicable)*
Patient Address *(Street, City, State, Zip Code)*	Daytime Phone Number *(include area code)*
Email Address:	

2. Release Purpose: *(how information will be used – ie, continuity of care, compliance for a school program, insurance, personal):* _____

3. Release Information FROM:

Check one box and complete if applicable.

☐ Missouri S&T Student Health Services

☐ Other – specify name of individual, organization, and/or department:

_____

Address/Street_____

City_____ State_____ Zip Code_____

Phone # (+ area code)_____

Fax # (+ area code)_____

Email Address (if applicable)_____

4. Release/Send Information TO:

Check one box and complete if applicable.

☐ Missouri S&T Student Health Services

☐ Other – specify name of individual, organization, and/or department:

_____

Address/Street_____

City_____ State_____ Zip Code_____

Phone # (+ area code)_____

Fax # (+ area code)_____

Email Address (if applicable)_____

5. Delivery of Information

Protected health information will be obtained or released via (check one):

☐ Fax ☐ Mail ☐ Phone/Verbal Communication ☐ CD/DVD/USB flash/thumb drive ☐ Pick up at SHS

☐ Email *(I understand email communications may not be secure unless encrypted)*

6. The Specific Records to Be Disclosed

Check all that apply:

☐ Entire Record including mental/behavioral health, drug/alcohol abuse, sexually transmitted infections including HIV, Hepatitis B/C, reproductive healthcare

☐ Entire Record excluding: _____

☐ Lab Reports (specify): _____

☐ Radiology Reports (specify): _____

☐ TB testing, chest x-ray, treatment records
☐ Immunization Records
☐ Lab titers

Dates of treatment to be released: Date(s)(mm-dd-yyy) _____ or Year(s)_____

This authorization will expire 1 year from date of signature *unless another date is specified:* _____

- Unless you revoke this Authorization in writing, this Authorization will expire 12 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 7-14 business days to process your request.

Office Use Only

Release Complete: # Pages _____
Faxed _____ Picked Up _____
US Mail _____ Campus Mail _____
Emailed _____
By _____ Date _____

Rev. 1/2025