AUTHORIZATION FOR RELEASE OF INFORMATION

Gustavus Adolphus College
Health Service
800 West College Avenue
St. Peter, MN 56082
Phone: 507-933-7630 Fax: 507-933-6074

Name (last)	(first)	(middle)	**Previous Name**
Address			**Day Phone #**
City	**State**		**Zip**
Date of Birth			**Social Security Number**

I hereby authorize: (name & address of releasing facility)

_____

_____

_____

To disclose medical information to: (name & address)

_____

_____

_____

Information to be disclosed:

Information as identified below (check all that apply) relating to (illness/injury) _____

Compiled during (visit date) _____

- ❑ Progress Sheets/Clinic Notes
- ❑ Lab
- ❑ X-ray Reports
- ❑ Pathology Report
- ❑ History & Physical
- ❑ Other _____

All records pertaining to psychiatric/mental health, chemical dependency and/or communicable disease (AIDS, ect. *If any information exists)* may be released unless otherwise specified here: _____

Purpose For Disclosure:

❑ Continuation of Medical Care ❑ Payment of claim ❑ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

As stated in the Notice of Privacy, I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Gustavus Adolphus College Health Service. I understand that the revocation will not apply to information that has been already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information, I can contact the Gustavus Adolphus College Health Service.

_____ _____

Signature of Patient Date

If patient is not able to sign, please indicate relationship to patient:

❑ Parent of Minor ❑ Legal Guardian ❑ Other ID Verification _____ Completed By _____ Date _____