Student Health Partners - Medical Services
PO Box 173260 - 100 Swingle
Bozeman, MT 59717
Phone: 406-994-2311
Fax: 406-994-2504
uhpmedical@montana.edu

Blue or Black pen only

Authorization For The Release of Health Information

Student Information

Name: _____ Date of Birth: _____

Student ID#: _____ Phone #: _____

Address: _____
Street City State Zip

Previous Names: _____

Who has the information you need?

I Authorize Montana State University - Student Health Partners Medical Services to:
Name of Provider

☐ Release health information -> **TO:** ☐ Request health information -> **FROM:**

Where do you want the information sent/received?

Name:_____ Relationship to Patient:_____

Agency Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

Method of Release

(choose ONLY one) o Picked Up o Mailed o Portal o Phone Calls o Faxed **If more than 20 pages - SHP will mail records

Information to be sent (initial all that apply)

Initial which Information is to be Released/Received

___ Office notes
___ X-ray reports
___ Annual exam/pap
___ Immunization records
___ Lab reports
___ X-ray images/CD
___ Sexual health/sti's
___Nutrition

_____ Dates of treatment
or
_____ All dates

Initial for Mental Health Records

_____ Psychological Test reports (i.e. ADHD/ADD report, etc.) _____ ADD/ADHD diagnosis
_____ Psychiatric Treatment
_____ Formal Psychiatric Evaluation _____ Dates of treatment or _____ All dates

Purpose of Disclosure

o Personal Records
o Legal
o Continuity/coordination of care
o Academic
o Insurance
o Other _____

I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to Student Health Partners – Medical Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that if the recipient is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations. This authorization will expire in **6 months** from my signature, **or a lesser period of time** as specified here: _____. I understand that this may include information regarding HIV/AIDS, sexually transmitted diseases, mental health status or treatment for alcohol and drug abuse. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

Patient Signature _____ **Date** _____

- By signing above, I understand and acknowledge the following.
- I have read and understand this authorization.
- If I have any questions about disclosure of my protected health information, I may contact the SHP Medical Services at Montana State University.