ROCHESTER
COMMUNITY AND TECHNICAL COLLEGE

Student Health Services
Phone: 507.285.7261
Fax: 507.285.7129

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION[1]

Student Name (print) _____ Date of Birth_____
Street Address _____
City, State, Zip _____
Student ID (Stinger) number* _____

I, _____
(Student or personal representative)
hereby **AUTHORIZE**:
Name of healthcare provider/plan/other:_____
Street Address:_____
City/State/Zip: _____

**TO DISCLOSE SPECIFIC HEALTH INFORMATION FROM THE RECORDS OF THE ABOVE-NAMED STUDENT TO**:
Recipient name:_____
Phone: _____ Fax: _____
Street Address:_____
City/State/Zip: _____

for the specific purpose(s): _____

**SPECIFIC INFORMATION TO BE DISCLOSED:**

| Information to be released: | Date of Service: | Information to be released: | Date of Service: |
|---|---|---|---|
| ( ) Info necessary for continued care | _____ | ( ) Labs _____ | _____ |
| ( ) History and Physical | _____ | ( ) Immunization Record | _____ |
| ( ) Progress Notes | _____ | ( ) Other _____ | _____ |

**You must specify if you wish to authorize release of information related to psychological or psychiatric conditions, HIV infection, AIDS or AIDS-related conditions, alcohol or drug abuse.* In compliance with Minnesota and Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

( ) Alcohol Abuse or test results
( ) Drug Abuse or test results
( ) Mental Health
( ) Developmental Disabilities
( ) HIV test results, AIDS or AIDS related diseases
( ) Sexually transmitted disease

**I understand** that this information will expire on the following date, event or condition:_____

**I understand** that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid for two years. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.
**I understand** that my information may or may not be protected from re-disclosure by the recipient of the information. If the recipient is not covered by privacy laws, the recipient could re-disclose the information.
**I also understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.
**I further understand** that I may request a copy of this signed authorization. A photocopy of this release is valid to the same extent as an original.

**Signature of Student**: _____ **Date**: _____

Personal Representative (if applicable). I represent and warrant that I am the Personal Representative of or otherwise legally authorized to act for the student named above and am signing this authorization in such capacity. Please describe your legal authority or relationship to student:_____

**Signature of Legal Representative**: _____ **Date**: _____

[1]Note to health care providers: This document complies with the requirements of the Health Insurance Portability and Accountability Act of 1996; the Minnesota Government Data Practices Act; and the Minnesota Health Records Act regarding authorizations to disclose protected health information. *See* 45 CFR 164.508 c)(1)(2002); Minn Stat. Sects. 13.05, Subd. 4(d); and 144.335, Subd. 3a (2002).

*If MnSCU requests an individual's Social Security Number, the following notice applies: You are not legally required to provide your Social Security Number, but if you do so, it will be used by provider staff to process this release and ensure the identity of the records. Failure to provide this number may result in delay or misidentification of records.

**Notice to recipients of information disclosed from alcohol or drug abuse treatment records protected by Federal confidentiality rules (42 CFR part 2).** The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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## REVOCATION SECTION

I hereby request that this authorization to disclose health information of _____
(Name of student)

signed by _____ on _____ be rescinded effective _____.
(Name of person who signed Authorization) (date of signature) (date)

I understand that any action taken on this authorization prior to this rescinded date is legal and binding.

Signature of Student: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

**Submit this form to Student Health Services by any of the following methods:**

- In person: HS140, First Floor Health Sciences
- By mail: RCTC Student Health Services
  851 30th Avenue SE Box 5
  Rochester, MN 55904
- By fax: 507.285.7129
- By e-mail: HealthServices@rctc.edu