Authorization to Release Protected Health Information to a Third Party

Form content retained in medical record.

TO BE SCANNED

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Student ID

Staff Use Only

☐ Faxed	☐ Scan to Chart
☐ Date	

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party (other than a family member or friend) such as an insurance company, employer, or for legal purposes, etc. Print clearly; each section needs to be completed to be valid.

1. Additional Patient Information

Previous or Maiden Name (if applies) *(First, Middle, Last)*	Daytime Phone
Patient Address *(Street, City, State, ZIP Code)*	

2. Release Purpose

Check appropriate box or write in other purpose.

☐ Continuing care ☐ Disability ☐ Forms completion ☐ Insurance ☐ Legal ☐ Payment of Claim

☐ Other, specify _____

3. Release Information FROM

Check one box and complete if applicable.

☐ **Gustavus Adolphus College Health Service**

☐ **Other,** specify organization, department, or individual (complete each line below)

_____

Street _____

City _____

State _____ ZIP Code _____

Phone _____

Fax _____

4. Release/Send Information TO

Check one box and complete each line for box checked.

☐ **Gustavus Adolphus College Health Service**

Fax. 507-933-6074 Attn. _____

☐ **Other,** specify organization, department, or individual (complete each line below)

_____

Street _____

City _____

State _____ ZIP Code _____

Phone _____

Fax _____

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

☐ **By checking this box** I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

☐ **By checking this box** I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

5. Delivery of Information

Preferred Method ☐ Written copy (may include completed forms) ☐ Verbal only	Date Information Needed by *(mm-dd-yyyy)*

Written information will be mailed unless an alternate method is checked.

☐ Fax (number listed above in section 4)

☐ Email Address _____

☐ Other, specify _____

Authorization to Release Protected Health Information to a Third Party (continued)

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Student ID

6. Records or Reports to Be Released

Timeframe to Be Released

Date(s)_____ or Year(s)_____
(mm-dd-yyyy) *(yyyy)*

- ☐ Immunization Records
- ☐ Progress Sheets/Clinical Notes
- ☐ Lab
- ☐ Xray Report
- ☐ Pathology Reports
- ☐ History and Physical
- ☐ Other _____

7. Signature and Date The patient or legal representative must sign and date this authorization.

- This authorization may be revoked at any time by providing a written notice of revocation to Gustavus Adolphus College Health Service.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I understand that Gustavus Health Service will not condition treatment on whether I sign this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Signature (required) ▶	**Date** (required) *(mm-dd-yyyy)* _____

Printed Name of Person Signing **(if not patient)** *(First, Middle, Last)*

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

☐ Parent ☐ Stepparent ☐ Legal guardian ☐ Foster parent ☐ Health care power of attorney/agent ☐ Other_____

Gustavus Health Service
800 W. College Ave
St. Peter, MN 56082
Ph. 507-933-7630
Fax. 507-933-6074

Reminder: If sending records **TO** Gustavus Health Service, fax records to number indicated in section 4 on page 1.