Winona State University Health & Wellness Services
175 W. Mark Street, Winona, MN 55987 - Phone: 507-457-5160 Fax: 507-457-2326

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

First Name_____ Middle Initial_____ Last Name_____

Address_____ City_____ State_____ Zip code_____

Date of Birth _____/_____/_____ Student Warrior ID _____ Phone (_____)_____

I authorize my health information be released ☐ ***FROM*** ☐ ***TO*** **(Must check one)**

Winona State University Health & Wellness Services
175 W. Mark Street Winona, MN 56001 Telephone: 507-457-5160 FAX: 507-457-2326

I authorize my health information be released ☐ ***FROM*** ☐ ***TO*** **(Must check one)**

☐ **Self (at above address) OR**

Name of facility/person_____
Address_____
City_____ State_____ Zip code_____

☐ I request my health information be faxed to: Fax: (_____)_____

☐ Other _____

☐ I authorize the Health & Wellness Services staff to discuss, share, and/or exchange my health Information as stated below with the person(s) here_____

HEALTH INFORMATION TO BE RELEASED (Please indicate on the health information you are Authorizing to be released.

☐ All health information included in my record

☐ Health information from (specify dates or treatment) _____

☐ Other information or instructions _____

Health information includes: any information about you related to mental health evaluation and treatment, concerns about drugs and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases, and genetic testing.

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information for it to be released:
☐ Psychotherapy notes
Patient Signature_____ Date_____/_____/_____

REASON FOR RELEASING INFORMATION:

☐ Patient's request ☐ Insurance purposes ☐ Personal use
☐ Continuation of care ☐ Legal ☐ Other _____

INFORMATION REGARDING THIS AUTHORIZATION: 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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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. If treatment is research-related, treatment 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.

This consent will end one year from the date the form is signed unless I indicate an event or earlier date here:
Specific evernt_____ Date_____/_____/_____

Patient's signature_____ Date_____/_____/_____