Sending or Disclosing Health Information by MTSU Student Health Services

Middle Tennessee State University
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MIDDLE TENNESSEE STATE UNIVERSITY

Name:_____
M # _____
DOB:_____
Phone: _____

I authorize Student Health Services (SHS) at Middle Tennessee State University, Murfreesboro, Tennessee, to use or disclose the above named individual's medical information as described below:

_____ Entire Record _____ Immunization Record
_____ Lab Results. Please list test(s)/date(s)_____
_____ Xray and Imaging Reports Please list test(s)/date(s)_____
_____
_____ Last visit. Please state date of service_____
_____ Other. Please specify date(s) of service or specific information _____
_____

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 or drug abuse. I do NOT authorize SHS to disclose any of the following information:

_____ AIDS/HIV _____ Alcohol/Drug Abuse
_____ Sexually Transmitted Diseases _____ Behavioral/Mental Health

This information may be disclosed to and used by the following individual or organization:

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Purpose of disclosure: ❑ At the request of the individual ❑ Other _____

❑ I will pick up the copies myself (Please allow 24 hours and please bring picture ID to pick up.)
❑ Please mail the copies to the address listed above.

THIS AUTHORIZATION DOES NOT EXTEND TO RECORDS MAINTAINED BY MTSU'S GUIDANCE AND COUNSELING CENTER.

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. However, SHS may deem the provision of health care for the purpose of disclosing to a third party protected health information specifically created for that third party, or for participating in research related treatment, upon my agreement to use and disclose this information.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to the Student Health Services to disclose my records, and that I may revoke this Authorization at any time by providing a written notice to the Student Health Services to the attention of Medical Records. The revocation shall be effective except to the extent that SHS has already used or disclosed information from the Authorization. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

Signature: _____ Date: _____.

The above authorization is given on this patient's behalf because the patient is a minor or is unable to sign for the following reasons: _____.

Signature: _____ Date: _____.
Relative/Guardian/Personal representative