



Hendrix Health Center
 MSU Moorhead
 Moorhead, MN 56563
 (218) 477-2211

NAME _____
 SSN _____
 GENDER: _____
 DOB: _____
 Phone: _____

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize the Hendrix Health Center at Minnesota State University Moorhead, Moorhead, MN, to use or disclose the above named individual's health information as described below.

The following information is to be disclosed:

- _____ Entire record _____ Immunization Record
- _____ Lab results Please list test(s)/date(s) _____
- _____ X-ray and imaging reports Please list test(s)/date(s) _____
- _____ Last visit Please state date of service _____
- _____ Allergy records
- _____ 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 HHC 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 to process and please bring picture ID to pick up). Copies going to another healthcare facility must be mailed to avoid a fee for copies.
- Please mail the copies to the address listed above.

THIS AUTHORIZATION DOES NOT EXTEND TO RECORDS MAINTAINED BY THE UNIVERSITY HEALTH CENTER'S COUNSELING AND PSYCHOLOGICAL SERVICES.

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. However, HHC 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 Hendrix Health Center to disclose my records, and that I may revoke this Authorization, except if this Authorization was obtained as a condition of obtaining insurance coverage, at any time by providing a written notice to the Hendrix Health Center to the attention of the Manager, Medical Records. The revocation shall be effective except to the extent that HHC has already used or disclosed information in reliance on 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

Date copy given to patient _____ Processed by _____ Date _____