

AUTHORIZATION FOR THE RELEASE OF MENTAL HEALTH INFORMATION

I hereby authorize the release of my health information

RELEASE FROM:

Name: _____
(Person or Clinic)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

RELEASE TO:

Name: _____
(Person or Clinic)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I specifically authorize the release of the following information: *** _____
(what illness, condition, treatment)

Reason for release of Information: _____
(e.g. transferring care, coordination of care, academic accommodations, completing a form, etc.)

LETTER/FORM COMPLETION VERBAL COMMUNICATION PRINTED COPIES OF RECORDS
*** ALL INFORMATION PERTAINING TO MENTAL HEALTH CARE, COUPLES THERAPY AND CHEMICAL HEALTH TREATMENT WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING

I specifically authorize the disclosure of the following information:

Mental Health Clinic Care _____ (Signature) _____ (Date)
 Couples/Family Therapy ★ _____ (Signature) _____ (Date)
★ (Both parties must complete a separate form)
 Chemical Health Treatment † _____ (Signature) _____ (Date)
† (Requires a separate signature)

PATIENT IDENTIFYING INFORMATION

Birthdate: ____ / ____ / ____

Name (Please Print) _____ Maiden/former/alias: _____

Student ID #: _____ Boynton Medical Record #: _____

Address: _____

Telephone - Home: () _____ Work: () _____

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the date of my signature.
- I understand that once information is released pursuant to this authorization, Boynton Health Service cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities for continuing care.
- Your treatment will not be conditioned on your signing this authorization except for research-related treatment.
- You are entitled to a copy of this *Authorization for the Release of Health Information*.

Signature of Patient/Authorized Person _____ Authorized Person's authority to sign _____ Date _____
A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

State of Minnesota)ss (NOTARY NEEDED ONLY IF PATIENT IS TO RECEIVE RECORDS)
County of _____) Signed before me on _____ by _____

Notary Public
My commission expires: _____

PLEASE CHECK ONE: I or _____ (valid picture ID required) will pick up the information at Boynton Information Desk on ____ / ____ / ____ . (Allow at least one week unless other arrangements are made with Correspondence at: (612) 624-2121 or FAX (612) 624-4414.)
 Mail the information to the address at the top of the page.
 FAX the information to: _____

Charge/Fee: _____

OFFICE USE ONLY
Completed by: _____ Date sent to Info.Desk: _____ Date Mailed: _____
Completed Form filed in Medical Record by: _____ Received by: _____

Boynton Health Service

Request for Documentation of Student Medical Condition

Student's Name: _____

I.D. Number: _____

Release of Information

Signed: _____

Date: _____

- Information will not be released without a valid Release of Information

Reason for Letter:

- Academic\Testing Accommodations _____
- Decrease number of credits Take incompletes Withdraw from class
- Withdrawal from semester _____ Take off a semester
- Retroactive withdrawal (which semester?) _____
- Tuition Reimbursement (which semester?) _____
- Visa related issue Financial aid Terminate dorm contract Missing a class
- Other: _____

Department or Individual requesting the letter: _____

Content of Documentation:

- Specific diagnosis & dates of treatment
- General medical statement & dates of treatment
- Other: (e.g. specific symptoms, medication side effects, other aspects or information limitations you feel are important considerations)

Student's telephone number: _____

- Pick up Mail to: _____ Fax to: _____

