

**Student Health Services**  
**Middle Tennessee State University**  
**PO Box 237**  
**Murfreesboro, TN 37132**  
**Phone (615) 898-2988**  
**Fax (615) 898-5004**

**Name:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

**SENDING OR DISCLOSING HEALTH INFORMATION BY MTSU: Student Health Services**

I authorize the Student Health Services Center ("SHS") at Middle Tennessee State University, Murfreesboro, TN, 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 \_\_\_\_\_  
\_\_\_\_\_ 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 to process 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

Date copy given to patient \_\_\_\_\_ Processed by \_\_\_\_\_ Date: \_\_\_\_\_

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Receiving Medical Records at MTSU Student Health Services

**TO:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the release of the following information to the **Student Health Services, Middle Tennessee State University, Murfreesboro, TN.** Fax number (615) 898-5004. Please send the records to the attention of \_\_\_\_\_.

- |                                   |                                   |
|-----------------------------------|-----------------------------------|
| _____ Initial evaluation          | _____ Entire medical record       |
| _____ Progress notes              | _____ History and physical        |
| _____ Consultation Reports        | _____ Psychological testing       |
| _____ Discharge/treatment summary | _____ Immunization Records        |
| _____ TB skin test                | _____ Women's Health notes        |
| _____ Allergy shot information    | _____ Laboratory/Cytology reports |

I further authorize you to discuss the above noted information with \_\_\_\_\_ at the Student Health Services.

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.

I understand that treatment, payment, enrollment, or eligibility in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization.

I understand that by refusing to sign this authorization may result in the doctor declining to provide the health care, which is for the sole purpose of creating protected health information for disclosure to a third party. Patient initials: \_\_\_\_\_

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 in writing at any time. This consent form will expire one (1) year following the date signed or upon my request.

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 reason:

\_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

\*Signature of Closest Relative or Legal Guardian (state relationship)