Receiving Medical Records at MTSU
Student Health Services

Middle Tennessee State University
MTSU Box 237
Murfreesboro, TN 37132
o: 615-898-2988 • f: 615-494-8866
mthealth@mtsu.edu

MIDDLE TENNESSEE STATE UNIVERSITY

TO: _____
_____
_____

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

I, _____, hereby authorize the release of the following information to the Student Health Services, Middle Tennessee State University, Murfreesboro, Tennessee. 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/Treatement 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 MTSU 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 refusing to sign this 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)