Sending or Disclosing Health Information by 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

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

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. List test(s)/date(s) _____
- ☐ Xray and Imaging Reports. List test(s)/date(s) _____
- ☐ Last visit. Please state date of service _____
- ☐ Other. 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 immune-deficiency 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: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

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

Select one:

- ☐ I will pick up the copies myself (Please allow 24 hours and please bring picture ID to pick up.)
- ☐ Fax to the number listed above.
- ☐ Mail the copies to the address listed above.
- ☐ Please email records to: _____

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. Even if I do not revoke this Authorization, **the Authorization expires automatically one (1) year from the date of signature below.**

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

0416-2912 - Middle Tennessee State University does not discriminate on the basis of race, color, national origin, sex, or disability. See our full policy at www.mtsu.edu/titleix.