COLLEGE OF
Saint Benedict Saint John's
UNIVERSITY

Authorization for Disclosure of Protected Health Information

Patient Name ____ Date of Birth ____________________

I hereby authorize The College of Saint Benedict and Saint John's University Health Services to:

☐ **Disclose to** ☐ **Obtain from** ☐ **Exchange with**

Name/Entity ____

Address ____

Phone ______________________________________ Fax ____

PURPOSE OF DISCLOSURE:

☐ Continuation of Care
☐ Other (please specify) ____

INFORMATION TO BE DISCLOSED:

☐ All Medical Records
☐ Laboratory/Pathology Reports
☐ Radiology Reports
☐ Immunizations Records
☐ Verbal Exchange Only
☐ Records Regarding Treatment for ____
☐ Other ____

DATES OF INFORMATION TO BE RELEASED: From ____________________ To _________________________

I understand that this authorization will remain in effect one (1) year from the date of signature. I also understand that it may be revoked by me in writing at any time but would not apply to any information already released in good faith. Any further disclosure of medical information by recipient(s) is not authorized without the specific written consent of the person to whom it pertains.
I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. A photocopy of this authorization will be treated in the same manner as an original.

Signature ____ Date ________________________
Patient or Legal Representative

HEALTH SERVICES
Well-Being Center
W www.csbsju.edu/health-services
P 320-363-5605

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