MONTANA STATE UNIVERSITY | Student Health Services

Medical Services
950 West Grant St
P.O. Box 173260
Bozeman, MT 59717-3180
Phone: 406-994-2311
Fax: 406-994-2504

Authorization for the Release of Health Information

Blue or Black Pen Only

Student Information	Name:_____ Date of Birth:_____ Student ID Number:_____Phone Number:_____
Request - **initial only one option**	I authorize Montana State University Student Health Services to: _____Release my health information to: _____ _____ (list name of provider, individual, or organization name) (provider phone number) _____Request my health information from: _____ _____ (list name of provider, individual, or organization name) (provider phone number)
Method of release - **initial only one option**	_____Faxed (preferred) _____Phone Call Only _____Mailed
Information to be sent – **initial all that apply**	_____Office Notes _____X-ray Reports _____Annual Exam/Pap _____Lab Reports _____X-ray Images _____Sexual Health/STIs _____Nutrition _____Immunizations _____Psychiatric Treatment _____ADHD/ADD Diagnosis _____Formal Psychiatric Evaluation _____Psychological Test Reports (ADHD testing, etc.)
Dates to be sent – **initial one option**	_____All Dates of Treatment _____Specific Dates of Treatment:_____ (enter dates or range of dates)
Purpose of this disclosure – **initial only one option**	_____Continuity of my care (preferred) _____Insurance _____Legal _____For my personal records _____Academic _____Other; define:_____
Return your signed & completed form - **choose one**	in person to Medical Services via email: studenthealth@montana.edu via fax: 406-994-2504 by mail: Montana State University - Medical Services P.O. Box 173260 Bozeman, MT 59717-3180

I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to Student Health Services - Medical Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that if the recipient is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations. This authorization will expire in 6 months from my signature, or a lesser period of time as specified here: _____. I understand that this may include information regarding HIV/AIDS, sexually transmitted diseases, mental health status or treatment for alcohol and drug abuse. 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.

By signing below, I understand and acknowledge the following:

I have read and understand this authorization.

If I have any questions about disclosure of my protected health information, I may contact Student Health Services at Montana State University.

Patient Signature:_____Date:_____

Form last updated 12/17/2024