Student Health Services
MINNESOTA STATE UNIVERSITY, MANKATO

AUTHORIZATION TO RELEASE ADD / ADHD HEALTHCARE INFORMATION

Patient Name: _____ Previous Name: _____

Date of Birth: _____ Tech ID: _____ Phone: _____

For Reason of Continuing Care, I request and authorize:

- Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder Diagnosis Including Assessment/Testing Records Be Released From:

Organization Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To Release Healthcare Information of the patient named above to:

Minnesota State University Mankato, Student Health Services
21 Carkoski Commons
Mankato, MN 56001
Phone: 507-389-6276 **Fax:** 507-389-5787

Information regarding this authorization:
I understand that each transfer of Medical Records requires a new release form signed by the patient. I understand that I may revoke the authorization at any time and that I will be asked to sign a written statement specifically revoking this authorization. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the recipient of the information. If the recipient is not covered by privacy laws, the recipient could re-disclose the information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A photocopy of this release is valid to the same extent as an original. This form can be found at www.mnsu.edu/shs/forms.html.

_____ _____

(Signature of Patient or Legal Representative) (**Date)**

OFFICE USE: Sent by _____ Date _____

THIS AUTHORIZATION EXPIRES SIXTY DAYS AFTER IT IS SIGNED. 11/18