IOWA STATE UNIVERSITY
Thielen Student Health Center

Thielen Student Health Center
2647 Union Drive
Ames, Iowa 50011
Phone: 515-294-5801
Fax: 515-294-5457

Authorization to Disclose Health Care Information

Release of Records (ROI)

Patient Information:

Patient Name:	
Current Address (City, State, Zip):	
University ID#:	Date of Birth (MM/DD/YYYY):
Phone #:	Email Address:

I hereby authorize the disclosure of my health care information by Thielen Student Health Center as indicated:

Send/Release: ☐ **From** ☐ **To**	**Send/Release:** ☐ **To** ☐ **From**
Thielen Student Health Center (TSHC)	Name:
2647 Union Drive	Address (City, State, Zip):
Ames, Iowa 50011	Phone:
Phone: 515-294-2614 Fax: 515-294-5457	Fax:
TSHC Records Dept. Email: shcreco@mail.iastate.edu	Email:
Method for Sending Records: ☐ Mail ☐ Fax ☐ Secure Email ☐ Hold for Pick-up	

Information Requested:	**Reason for Release:**
☐ Immunizations/titers dates: _____	☐ Continuing care*
☐ X-ray dates/condition: _____ ☐ X-ray report (no image) ☐ X-ray image (CD)	☐ Transfer of care*
☐ Lab(s) dates/condition: _____	☐ Legal/attorney
☐ Billing information dates: _____	☐ Insurance purposes
☐ Physical Therapy dates/condition: _____	☐ Personal use
☐ Verbal or written information to parent/guardian: ☐ All Specify:_____	☐ Other (specify):_____
☐ My complete Medical Records from/to the following dates: _____ or about the following condition:_____	**Written authorization not required,* ***unless*** *PHI includes HIV/AIDS or Sexual Assault Exam Information*
☐ Other (specify):_____	

Additional Consent: To be included in this release of records, **you must indicate,** with your initials, the specific information TSHC may disclose for the following types highly sensitive medical records (if applicable):

Substance Abuse_____ Mental Health_____ HIV/AIDS_____ Sexual Assault Exam Information_____

Further, I agree and understand that:

1. This authorization may be revoked at any time by notifying TSHC in writing except to the extent that action has been taken in reliance on it.
2. I can request an accounting of disclosed information by writing to the TSHC Health Information Privacy Officer at the address above.
3. My refusal to sign, or revocation of, this authorization will not affect my ability to obtain health care services from TSHC.
4. The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.
5. There may be a fee associated with the copying of records.
6. This agreement will expire one year from the date of signature below, unless previously revoked or otherwise indicated here: _____

Patient's Printed Name

Today's Date (MM/DD/YYYY)

Patient's Date of Birth (MM/DD/YYYY)

Patient's University ID#

Signature of Patient (or Legal Representative, if applicable)

If applicable, Legal Representative's Printed Name and Relation to Patient (e.g., Mother, Father, Guardian, etc.)

 ☐ No patient signature required: care coordination/transfer of Care ☐ ROI Faxed: Date_____ Staff initials_____