

# Receiving Medical Records at MTSU Student Health Services

Middle Tennessee State University  
MTSU Box 237  
Murfreesboro, TN 37132  
o: 615-898-2988 • f: 615-898-5004  
mthealth@mtsu.edu



TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
M # \_\_\_\_\_  
DOB: \_\_\_\_\_  
Phone: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the release of the following information to the Student Health Services, Middle Tennessee State University, Murfreesboro, Tennessee. Fax number 615-898-5004. Please send the records to the attention of \_\_\_\_\_.

- |                                   |                                   |
|-----------------------------------|-----------------------------------|
| _____ Initial Evaluation          | _____ Entire Medical Record       |
| _____ Progress Notes              | _____ History and Physical        |
| _____ Consultation Reports        | _____ Psychological Testing       |
| _____ Discharge/Treatment Summary | _____ Immunization Records        |
| _____ TB Skin Test                | _____ Women's Health Notes        |
| _____ Allergy Shot Information    | _____ Laboratory/Cytology Reports |

I further authorize you to discuss the above noted information with \_\_\_\_\_ at MTSU Student Health Services.

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.

I understand that treatment, payment, enrollment, or eligibility in a health plan or eligibility for benefits is NOT dependent on my signing this Authorization.

I understand that refusing to sign this may result in the doctor declining to provide the health care, which is for the sole purpose of creating protected health information for disclosure to a third party. Patient Initials \_\_\_\_\_

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 in writing at any time. This consent form will expire one (1) year following the date signed or upon my request.

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 reason:

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

\*Signature of Closest Relative or Legal Guardian (state relationship)