Morehead State University
Student Health Services
Authorization for Release of Compliance Information/Consent for Departmental Drug Screening

Fill in answers to each item below: The patient or patient's legal representative must sign this completed authorization before any information will be released.

Patient Name_____
Last First Middle

Address_____

Phone_____ Date of Birth_____ Social Security Number_____
MSU ID#_____

I authorize **Student Health Services**_____ to release department compliance information and/or urine drug screen results to _____

I understand that released information will be used for the purpose of my program requirements for participation in University programs.

Information to be released may include:

- **Immunization Records, including TB Screening Results**
- **CPR Certification**
- **Licensure Validation (when applicable)**
- **Departmental Mandated Urine Drug Screen Results**

I understand that this consent allows the identified individuals within the _____ **department ,** to have access to the above information. This will include being able to access the above information through **Online Student Health when applicable.** Access will only be available to review and print the above noted information and no other portion of the electronic medical record.

I understand this consent can be revoked (in writing) at any time except to the extent that disclosure made in good faith has already occurred.
I also understand this authorization will remain in effect as long as I remain in the above noted program **at Morehead State University.**

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

The facility, its employees and officers and attending medical practitioner(s) are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

I understand that I may refuse to sign this authorization and that if I do refuse, this will not affect by ability to obtain treatment at this facility.

_____ _____
Date Signature

If patient is unable to sign, secure consent of
Legal Representative and indicate reason below:

_____
Signature of Legal Representative Relationship

___Minor
___Other

_____
Signature of Witness

FOR OFF CAMPUS STUDENTS, PLEASE RETURN FORM TO COUSELING & HEALTH SERVICES 112 ALLIE YOUNG HALL, MOREHEAD KY 40351 or fax to 606-783-9106