UNIVERSITY OF MINNESOTA
Twin Cities Campus
Boynton Health Service
Office for Student Affairs
410 Church Street S.E.
Minneapolis, MN 55455
www.bhs.umn.edu

IMMIGRATION

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I authorize Boynton Health Service to release to: _____

Address: _____
information regarding immigration physical including all laboratory tests and x-ray results to be used for IMMIGRATION APPLICATION REQUIREMENTS.

PATIENT IDENTIFYING INFORMATION

Name (Please Print) _____ Birthdate: ____/____/_____

Student ID #: _____ Boynton Medical Record #: _____

Address: _____

Telephone - Home: ( ) _____ Work: ( ) _____

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the date of my signature.
- I understand that once information is released pursuant to this authorization, Boynton Health Service cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities for continuing care.
- Your treatment will not be conditioned on your signing this authorization except for research-related treatment.

Signature of Patient/Authorized Person *(If authorized person signing, also print name.)*	Authorized Person's authority to sign *(Parent, guardian, power of atty., etc.)*	Date

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other _____

PLEASE CHECK ONE: ☐ I or _____ (valid picture ID required) will pick up the information at Boynton Information Desk on ___/___/_____. Patient Accounting Office will contact you when documents are made available. (Allow at least two weeks unless other arrangements are made with Correspondence at: **(612) 624-2121 or FAX (612) 624-4414.**)

Charge/Fee:_____

☐ Mail the information to the address at the top of the page.

OFFICE USE ONLY
*R*eceived by: _____
Completed by: _____ Date sent to Info.Desk: _____ Date Mailed: _____
Completed Form filed in Medical Record by: _____