UND STUDENT HEALTH SERVICES
UNIVERSITY OF NORTH DAKOTA

John A. Swenson Student Health Services
McCannel Hall, Room 100
2891 2nd Avenue N., Stop 9038
Grand Forks, ND 58202-9038
Phone: 701.777.4500 Fax: 701.777.4835

Place **Patient Label** Here

(For Clinic Use Only)

Name: _____ UND ID# _____
DOB: ____/_____/_____ Maiden/former/alias:_____
Telephone:_____
Address:_____
City:_____ State:_____ Zip:_____

AUTHORIZATION FOR RELEASE OF INFORMATION - MEDICAL RECORDS

The above named individual authorizes UND Student Health Services to exchange, release and/or receive, as described below, confidential information to/from:

Name/Organization:

_____ **Telephone #** _____

_____ **Fax #** _____

_____

Information to be released/received:

□ Chart Notes □ Laboratory Results □ Pathology Reports (PAP, biopsy)
□ Immunizations/TB testing □ Depo orders/Last Shot □ Imaging/Diagnostic Reports (x-ray, CT, MRI)
□ ADD/ADHD Testing/Records □ Other (Please specify): _____

The released information may contain the following unless specifically restricted, indicated by initialing items you DO NOT want included:
Behavioral Health records _____ (initials) HIV/AIDS Testing/Treatment _____ (initials)
Genetic Testing _____ (initials) Chemical Dependency/Substance Abuse _____ (initials)

Covering the period(s) of healthcare from (date) _____ **to (date)** _____ ***(or 1 year from date of signature unless specified).***

Purpose of disclosure: ☐ Continued Medical Care ☐ Legal ☐ Personal ☐ Insurance purposes ☐ Other _____

Please indicate how you prefer your health information be communicated:

☐ Send my records by mail ☐ Send my records by fax ☐ Oral communication ☐ Hand carry by_____ ☐ Other:_____

NOTICE:

- I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above.
- Further disclosure of confidential information without the specific written consent of the person to whom it pertains is prohibited by state and federal laws. I understand that information in confidential records cannot be released without my written consent unless otherwise provided in state and federal laws and court orders.
- NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records protected by Federal confidentiality rules 42 CFR part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical and other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- I understand that in the event I am authorizing the disclosure of my treatment information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal law.
- I understand that I am entitled to a copy of this Authorization for the Release of Information (ROI) – Medical Records.

This authorization shall be in effect for 12 months following the date of the signature. A photocopy or reproduction of this document is as valid as the original.

_____ _____ _____
Signature of Patient/Authorized Person Authorized Person's printed name/Authority to sign Date

Reason Patient Is Unable to Sign: ☐ Minor ☐ Deceased ☐ Other_____