



John A. Swenson Student Health Services
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AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

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

I specifically authorize the release of the following information:

- Progress/Chart Notes History & Physical Pap/Pelvic Reports Immunizations
- Lab Reports X-ray Reports ADD/ADHD records/testing Chemical Dependency
- Psychiatry Notes HIV/AIDS Consultation Report(s) Last Depo shot & orders
- Other, please specify _____

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

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

Records Released From:

Records Released To:

Fax # _____

Fax # _____

Check how you prefer your health information be communicated:

- Send my records by mail Send my records by facsimile Oral communication Hand carry by _____

- 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.
- I understand that information may not be re-released under this authorization by the person or organization to which it is sent. The privacy of this information is protected under the Federal Education Rights and Privacy Act (FERPA).
- I understand that the Chemical Dependency client's/patient's records are protected by federal law and cannot be disclosed without this written consent unless otherwise provided in the federal regulations.
- I understand that there is no charge for the release of information to other health care entities for the purpose(s) of continuity of care. Charges will be incurred for the release of information for any purpose other than continuity of care pursuant to ND Open Records law.
- I understand that UND Student Health Services may not condition my treatment or payment of my bills on my decision to sign this authorization.
- I understand that I am entitled to a copy of this Authorization for the Release of Health Information.

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
(If authorized person signing, also print name)

Authorized Person's authority to sign

Date

Reason Patient Is Unable to Sign: Minor Deceased Other _____

SHS OFFICE USE ONLY:

Completed by: _____ Date : _____

Fee Assessed: No Yes \$ _____