



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)

AUTHORIZATION FOR RELEASE OF INFORMATION - MEDICAL RECORDS

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

Information to be released:

- 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 _____

Records Released **From** (Name and Address): _____

Fax # _____

Records Released **To** (Name and Address): _____

Fax # _____

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.
- 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 _____