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

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:

_____

_____

_____

Fax # _____

Records Released To:

_____

_____

_____

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 $_____