UND STUDENT HEALTH SERVICES
THE 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

Medical Record #_____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name: _____**University ID#**_____ **DOB:** ____/____/19____

Address:_____**City:**_____**State:**_____**Zip:**_____

SPECIFIC INFORMATION TO BE DISCLOSED

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

- ☐ Progress Notes
- ☐ History & Physical
- ☐ Pap/Pelvic Reports
- ☐ Laboratory Reports
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ Immunizations
- ☐ Consultation Report(s)
- ☐ Other, please specify_____

PURPOSE OF THE DISCLOSURE: (please specify): _____

I, Authorize:	**To Release to:**
UND Student Health Services	_____
McCannel Hall Room 100, 2891 2nd Ave. N, Stop 9038	_____
Grand Forks, ND 58202-9038	_____

Check how you prefer your health information be communicated

☐ Send my records by mail ☐ *Send my records by facsimile ☐ Hand Carry

*Fax # ( ) _____-_____ (Facsimile transmission of medical records is discouraged and should only be utilized when mailing would not meet the immediate needs of the patient. Student Health Services will disclose medical information by facsimile transmission with the patients understanding and written consent that this type of communication does not ensure confidentiality.

Please initial the following statement after reviewing: _____I have read the previous statement regarding facsimile transmission and give Student Health permission to send my authorization for disclosure of my medical records by facsimile transmission.

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 disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand the UND Student Health Services may not condition my treatment or payment of my bills on my decision to sign this authorization.

A photocopy is as valid as the original record.

Patient Signature:_____**Date**:_____

This authorization shall be in effect for 12 months following the date of the signature.

SHS OFFICE USE ONLY:

Date Record(s) Sent: _____ Signature of Sender _____