NDSU | STUDENT HEALTH SERVICE

North Dakota State University | Student Health Service
NDSU Dept. 2842 • P.O. Box 6050 • Fargo ND 58108-6050
Phone: (701) 231-7331 • Fax: (701) 231-6132

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name ______________________________ / ______________________ / ________
Last (Previous Name) First MI

Date of Birth ________ /________ /________ Student ID# ____________________ Phone ( ) ____________________
mm dd year

1. I HEREBY AUTHORIZE NDSU STUDENT HEALTH SERVICE TO: (check appropriate box)

❑ Release to: ❑ Receive from: ❑ Exchange with:

List name(s): ____

2. METHOD OF RELEASE:
(NOTE: we cannot guarantee privacy and security when sending records via email. If you select this option and sign this form, you assume risk associated with your records being sent in email format. Emails will be sent in a secure file transfer format.)

❑ Pick up records from Student Health Service ❑ Email: ______________________

❑ Fax: ______________________ ❑ Other: ______________________

❑ Mail: ____
(list address including city, state and zip code)

3. INFORMATION TO BE RELEASED: (check all applicable)

❑ Clinic Visit Notes ❑ Lab Reports ❑ TB Records ❑ X-ray Reports

❑ Mental Health Notes ❑ HIV/AIDS Lab Reports ❑ Genetic Screening/Testing ❑ Billing Statements

❑ Immunizations ❑ STI Lab Reports ❑ Other: ______________________

4. RECORDS FROM THE TIME: ________ /________ /________ through ________ /________ /________
mm dd year mm dd year

5. PURPOSE OF DISCLOSURE: (check applicable purposes)

❑ Continued Medical Care ❑ Legal ❑ Personal ❑ Insurance purposes ❑ Other ______________________

6. Upon fulfillment of the above stated purpose(s) or at the end of one year, whichever is sooner, this consent will automatically expire.
7. I understand that authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization.
8. I understand I have the right to revoke this authorization, in writing, at any time except to the extent that action has already been taken.
9. I understand the information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
10. NDSU Student Health Service will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
11. A photocopy of this authorization will be treated in the same manner as the original.
12. Chemical Dependency records are further protected by a more stringent Federal law (42 CFR Part 2). This information cannot be disclosed without the expressed authorization of the client nor can the information be re-disclosed unless specifically authorized by the client or as otherwise permitted by 42 CFR Part 2.

____ **By initialing this space, I authorize the release of information pertaining to chemical dependency, including alcohol or drug treatment records protected under federal law information. If this box is not checked, the documents containing chemical dependency treatment information will not be released.**

____ Date ________ /________ /________
Signature of Patient or Patient Representative mm dd year

____ Date ________ /________ /________
If signature by other than patient, state authority and relationship mm dd year