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.)

   ❑ 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)

   ❑ Appointment Notes ❑ Lab Report(s) ❑ GYN Report(s) ❑ Financial

   ❑ Xray Report(s) ❑ Immunization(s) ❑ Allergy ❑ 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. I understand this authorization shall be valid for one year after which time it will automatically expire without my express revocation.
7. 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.
8. 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.
9. 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.
10. A photocopy of this authorization will be treated in the same manner as the original.

_____ Date _____ /_____ /_____
Signature of Patient or Patient Representative mm dd year

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

Special Authorization:
Check all applicable box(es) and sign below. By signing below, I am authorizing NDSU Student Health Service to release any and all information regarding: ❑ Alcohol ❑ Drugs ❑ Mental Health ❑ Sexually Transmitted Diseases ❑ HIV ❑ AIDS

Note: If this release pertains to alcohol, drug or mental health information, please note that 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 additional further disclosure is expressly permitted by written consent to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or 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.

_____ Date _____ /_____ /_____
Patient's Signature mm dd year

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

STUDENT HEALTH SERVICE USE ONLY: Date received: _____ Date processed: _____ Processed by (initials): _____