



WALLMANwellnessCENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

North Dakota State University – Student Health Service
NDSU Dept. 5150 • P.O. Box 6050 • Fargo, ND 58108-6050 • Tel. (701) 231-7331 • Fax (701) 231-6132

Patient Name _____
Last First MI DOB ____/____/____
mm/dd/year

Student ID # _____ Telephone () _____

1. I AUTHORIZE:

2. TO RELEASE TO:

Name of sending medical facility

Name of receiving person/organization

Street Address

Street Address

City State Zip

City State Zip

3. Information to be released: (Check all applicable) Phone _____ Fax# _____

- All information* Progress Notes Lab Reports GYN Report
- X-ray reports Immunizations Allergy Other _____

*Charge may apply

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.

Patient's Signature _____ Date ____/____/____

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

5. PURPOSE OF DISCLOSURE: (check applicable purpose)

- 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.

Signature of Patient or Patient Representative

Date mm / dd / year

If signature by other than patient, state authority and relationship

Date mm / dd / year

STAFF USE ONLY Chart # _____ Date received _____ Date released _____ Release approved by _____

- Request verified by photo ID or matching signature
- Released by: Mail Fax To Patient Certified Mail Other _____