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

Place **Patient Label** Here

(For Clinic Use Only)

Name: _____UND ID# _____

DOB: ____/_____/_____Maiden/former/alias:_____

Telephone:_____

Address:_____

City:_____ State:_____ Zip:_____

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH RECORDS

The above named individual authorizes UND Student Health Services to exchange, release and/or receive, as described below, confidential information to/from:

Name/Organization:

_____ **Telephone #** _____

_____ **Fax #** _____

_____

Circle the "Yes" or "No" of information to be released/received for each item:

Information to be released by Student Health Services		
Yes	*No*	Termination Summary/Planning
Yes	*No*	Intake Assessment
Yes	*No*	Chemical Dependency Evaluation
Yes	*No*	Treatment/Plans Recommendations
Yes	*No*	Progress in Treatment
Yes	*No*	Psychological/Psychiatric Consults
Yes	*No*	Acknowledgement of Client's Access of Services
Yes	*No*	Any information pertinent to treatment or plan
Yes	*No*	Other:

Information to be received by Student Health Services		
Yes	*No*	Termination Summary/Planning
Yes	*No*	Intake Assessment
Yes	*No*	Chemical Dependency Evaluation
Yes	*No*	Treatment/Plans Recommendations
Yes	*No*	Progress in Treatment
Yes	*No*	Psychological/Psychiatric Consults
Yes	*No*	Acknowledgement of Client's Access of Services
Yes	*No*	Any information pertinent to treatment or plan
Yes	*No*	Other:

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

Purpose: The purpose of this release is to facilitate the assessment, treatment planning, and discharge planning regarding the client who has accessed the UND Student Health Services. ☐ Other (specify): _____

Please indicate how you prefer your health information be communicated:

☐ Send my records by mail ☐ Send my records by fax ☐ Oral communication ☐ Hand carry by_____ ☐ Other:_____

- 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 Disclosure of Mental Health Records.

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_____