

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

I hereby voluntarily authorize the disclosure of information from my record.

|  |  |
| --- | --- |
| Name | Previous Name |
| Address | City/State/Zip |
| Phone | Date of Birth |

**Release my records from:**

|  |  |
| --- | --- |
| Name of facility | Phone |
| Address | |
| City/State/Zip | FAX |

**My records will be provided to:**

United Tribes Technical College Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Health Department Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3315 University Drive

Bismarck, ND 58504 **FAX: 701-530-0645**

**Purpose of the release:**

□ Continued care □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclose the following information from my health record:**

□ Past ONE year

□ ONLY information related to a specific (circle) diagnosis, injury, operation, therapy, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Only period or date range from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ I agree to waive my psychotherapist-patient privilege and would like the following sensitive** **information released:**

□ Sexually Transmitted Disease diagnosis and/or treatment

□ HIV/AIDS related diagnosis and/or treatment

□ Mental Health (other than psychotherapy notes)

**I understand the following:**

* If I change my mind, I may write to the address above and stop the release of my records. This will not apply to records that have already been released.
* Once the records are released, the clinic or hospital releasing my records cannot prevent them from being released to a third party. Released records may no longer be protected by state and federal privacy laws.
* I understand that any records related to Chemical Dependency are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in federal regulations.
* To be valid, this form must be filled out completely and signed by the patient or authorized representative.
* A copy of this form is valid if it has not been altered.
* This form expires one year from the date that I signed below unless otherwise specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or authorized representative Date