

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 FOR DISCLOSURE OF PROTECTED HEALTH 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 VERBALLY RELEASE RECORDS TO:**

List name(s): \_\_\_\_\_

**2. PASSPHRASE:**

All individuals listed on this authorization must be able to provide the passphrase along with the patient's full name and date of birth before information will be disclosed. It is the patient's responsibility to share this passphrase with the individual(s) listed above.

Passphrase: \_\_\_\_\_

**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.

\_\_\_\_\_  
 Signature of Patient or Patient Representative Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm dd year

\_\_\_\_\_  
 If signature by other than patient, state authority and relationship Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
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.

\_\_\_\_\_  
 Patient's Signature Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm dd year

**STUDENT HEALTH SERVICE USE ONLY:** Date received: \_\_\_\_\_ Date processed: \_\_\_\_\_ Processed by (initials): \_\_\_\_\_