



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		
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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 _____