UND School of Medicine & Health Sciences
University of North Dakota

Center for Family Medicine

Authorization for Release of Information

Patient Name: _____ Maiden/Other Name: _____

Date of Birth: _____ Phone Number: _____

I authorize release of information from:	To be released to:
_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City State Zip Code	City State Zip Code
_____	_____
Phone Fax	Phone Fax

PURPOSE OF THIS REQUEST ❑ Personal Use ❑ Legal ❑ Insurance ❑ Military ❑ School
❑ Continued Medical Care ❑ Other (specify) _____

INFORMATION TO BE RELEASED ❑ Last 2 years of medical history ❑ Other _____

Records that are of a sensitive nature will not be released unless specifically authorized below.
Any patients 14 years old or older must authorize the release of their own sensitive information

❑ Psychiatric/Mental/Chemical Dependency Date: _____
❑ HIV Date: _____
❑ Contraception/STD (if ages 14-17) Date: _____

I understand that if records are released to someone who is not a healthcare provider, health plan or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may be further disclosed without obtaining authorization.
I understand that I have a right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form by contacting the Records Information Department.
I understand that if I sign this authorization, I have a right to receive a copy of this form, if requested.
I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature. However, our medical treatment of the patient is not conditional on the signing or failure to sign this form. This authorization is effective for one year unless otherwise specified as follows: _____.
I understand I may cancel this authorization at any time by written notification. I am aware that my withdrawal will not be effective to uses and or disclosures of my health information that may have already been released. For information regarding how to withdraw my authorization or to receive a copy, I may contact the Medical Records Department.
I have had opportunity to review and understand the contents of this authorization. By signing this authorization, I am confirming that it accurately reflects my wished. I release the staff of the Center for Family Medicine from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

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Please return completed form by mail, fax or email

UND Center for Family Medicine
Attention: Medical Records
1201 11th Ave SW
Minot ND 58701
****

Fax: (701) 858-6811
Attention: Medical Records
****

Email: minotcfm@und.edu
Subject: Medical Records Release

If you need assistance completing this form,
please call (701) 858-6706
Toll Free: (800) 841-7321 Option 3