University of Minnesota, Duluth Health Services
615 Niagara Court, Duluth, MN 55812
Reception - (218) 726-8155 (218) 726-6132 Fax Nurse's Station - (218)726-7863 (218) 726-8515 Fax

Authorization for Disclosure of Health Information

PLEASE PRINT
Patient Name: _____ Date of Birth: _____UMD ID#_____

I hereby authorize: ( ) Disclose to ( ) Obtain from ( ) Exchange with

UMD Health Services
615 Niagara Court
Duluth, MN 55812-3065

_____
Facility / Organization

_____
Address

_____
City / State/ Zip Code

(_____)_____ (_____)_____
Phone Number including area code Fax Number including area code

PURPOSE OF DISCLOSURE:
( ) Transfer to another clinic
( ) Continued Care
( ) Personal Use
( ) Other _____
_____

I specifically authorize the release of information relating to:
( ) Psychological Health
( ) Substance abuse (including alcohol/chemical use)
( ) Sexually transmitted infections
( ) HIV related information (AIDS related testing)

_____ _____
Signature of Patient or Legal Representative Date

SPECIFIC INFORMATION TO BE RELEASED:
( ) Any and all Medical Records
( ) History and physical
( ) Progress/Provider Notes
( ) Laboratory Reports/X-ray reports
( ) Recent pap/pelvic/PE/OCP records/Depo injections
( ) Records regarding treatment for _____
(Specific Condition or Injury)
( ) Conversations between providers
( ) Immunization Records
( ) Diagnosis / Treatment Plan
( ) Other _____

DATES OF INFORMATION TO BE RELEASED: From _____ / _____ / _____ to _____ / _____ / _____

May Information Be Sent By FAX: ( ) Yes ( ) No _____
Signature

Information regarding this authorization:
- Each transfer of Medical Records requires a new release form signed by the patient.
- This form allows exchange of Counseling/Mental Health Records for one year.
- I may revoke this consent at any time by providing UMD Health Services with a written statement specifically revoking this authorization.
- I will receive a copy of this authorization form upon my request.
- By authorizing the use or disclosure of information, there will be no conditions placed on my health care.
- Information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.
- In compliance with MN Statue 144.33, I may be required to pay a fee for retrieval and photocopying of records and/or a supervised inspection of medical records.

I have reviewed and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

_____ _____
Signature of Patient or Legal Representative Date