



### 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



Please return completed form by mail, fax or email

UND Center for Family Medicine  
Attention: Medical Records  
1201 11<sup>th</sup> Ave SW  
Minot, ND 58701

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

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[minotcfm@med.und.edu](mailto:minotcfm@med.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