UND SCHOOL OF MEDICINE & HEALTH SCIENCES
UNIVERSITY OF NORTH DAKOTA
DEPARTMENT OF SPORTS MEDICINE

CENTER FOR SPORTS MEDICINE
Hyslop Sports Center, Room 115
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AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Student Name: _____ **DOB:** _____/_____/_____

Maiden/former/alias: _____ **Phone:** _____

_____ _____ _____ _____
Street Address City State ZIP

I specifically authorize the release of the following information

- ☐ Initial evaluation
- ☐ Progress notes
- ☐ Discharge summaries
- ☐ Daily treatment/rehab log
- ☐ Referral
- ☐ Billing
- ☐ History and physical
- ☐ Helmet waiver
- ☐ Concussion waiver
- ☐ Sickle cell waiver/ testing results
- ☐ ADHD documentation
- ☐ Imaging report/nerve conduction testing
- ☐ Lab results
- ☐ Psychotherapy documentation
- ☐ Counseling documentation
- ☐ Insurance information
- ☐ Photographs/videos
- ☐ Medical Doctor notes
- ☐ Chiropractic notes
- ☐ All records
- ☐ Other (please specify): _____

From: _____ To: _____

Covering the period(s) of healthcare from (date) _____ to (date) _____ (one year unless specified) and for the purpose of _____
(please specify)

Check how you prefer your health information be communicated **Send my records by: (check all that apply)**

☐ Mail:_____ ☐ Fax:_____ ☐ Hand Carry:_____

☐ Oral Communication ☐ Text Messaging:_____ ☐ Email:_____

- 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 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 Department of Sports Medicine 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 Release of Health Information.

This authorization shall be in effect for twelve (12) months following the date of the signature. A photocopy or reproduction of this document is as valid as the original.
Under HIPAA Rules and Regulations, communication by fax, text messaging or email can put your Personnal Health Information (PHI) at risk. By signing below, you fully acknowledge the risk.

_____ _____ _____
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:_____

UND Department Use Only

Completed by:_____ Date: _____

Fee assessed: ☐ No ☐ Yes: $ _____