

REVOCATION DATE: \_\_\_\_\_

**THE UND PSYCHOLOGICAL SERVICES CENTER**

P.O. Box 7108 Grand Forks, North Dakota 58202-7108  
701.777.3691

**Authorization to Release Confidential Clinical Records and Exchange Protected Health Information**

1. Information from the Medical Record of:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Contact Phone Numbers: \_\_\_\_\_  
Maiden/Former Name: \_\_\_\_\_

2. I authorize:

**The UND Psychological Services Center**  
**P.O. Box 7108**  
**Grand Forks, North Dakota 58202-7108**  
**(701) 777.3691**  
**GSA** \_\_\_\_\_

To Release To  To Request From  To Exchange With  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Information to be released: \_\_\_\_\_

A checkmark in the box indicates specific release of records related to:  HIV  Chemical Dependency

4. Purpose of disclosure: \_\_\_\_\_

5. The information may be communicated in oral and/or written format.

6. This authorization shall be in effect for 12 months following the date of signature.

8. A photocopy of this form is as valid as the original.

7. I understand that my/my child's records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations including Federal Law Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164). I also understand that I may revoke this Authorization at any time except to the extent that action has been taken on it or if this Authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information is limited to staff whose work assignments reasonably require access to my/my child's data within the purposes specified in the services provided. I understand that my/my child's therapist (GSA) may not condition psychological services upon my signing an Authorization, unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient/Guardian \_\_\_\_\_ Relation: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness \_\_\_\_\_

**Disclosure Log:**

Date	Action Taken	Staff Initials	Date	Action Taken	Staff Initials