FORM #SH002

JOHN A. SWENSON STUDENT HEALTH SERVICES
P.O. Box 9038, Grand Forks, ND 58202
Phone: 701.777.4500 Fax: 701.777.4835

DISCLOSURE OF MEDICAL RECORDS

reasonable fees will be assessed for medical record release
($1.00 per page up to 5 pages, $30.00 for 6 or more pages, no charge for immunization records, or to other healthcare providers)

Patient Name: _____**Medical Record #** _____

Date of Birth: _____/_____/19_____ **Social Security Number:** _____-_____-_____

SPECIFIC INFORMATION TO BE DISCLOSED (specify dates for each, unless *complete medical record" is requested)

☐ History and Physical _____ ☐ Consultation Report (s) _____ ☐ X-Ray Reports _____ ☐ Pap/Pelvic Reports _____

☐ Laboratory Reports _____ ☐ Immunizations _____ ☐ X-Ray Films _____ ☐ Complete Medical Record

☐ Other (please specify) _____

PURPOSE OF THE DISCLOSURE

☐ Insurance Determination ☐ Legal/Attorney ☐ Vocational Rehab ☐ Disability

☐ Personal Records ☐ Military Records ☐ Education ☐ Research Study

☐ Continuity of Care ☐ Other (please specify):
_____

Please request my records from[1]: _____

_____

_____

Please send my records to: _____

_____

_____

Check how you prefer your health information be communicated

☐ Send my records by mail ☐ *Send my records by facsimile[2] ☐ Mail my records to me ☐ Hand Carry

*Fax # ( ) _____-_____ (I have read the footnote regarding facsimile transmission, and give Student Health permission to send my request for disclosure of my medical records by facsimile transmission)

Patient Signature:_____**Date**:_____

Signature of parent or guardian (as applicable): _____ Relationship:_____ Date: _____

[1] I, the patient, understand if I request information be disclosed to a non-covered agency, that this information may be subject to re-disclosure, and will no longer be protected under HIPAA.

[2] Facsimile transmission of medical records is discouraged and should only be utilized when mailing would not meet the immediate needs of the patient. With patient written consent, Student Health Services will disclose medical information by facsimile transmission, with the patients understanding that this type of communication does not ensure confidentiality.

6/4/03 FEE: $ _____Cash/Check/Billed: $_____

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: production of the medical records requested herein, or on (date): _____

Date Request Sent: _____ Signature of Sender _____ Copy of request to patient (v):_____

FEE: $ _____Cash/Check/Billed: $_____