

**University of Minnesota, Duluth Health Services**

615 Niagara Court, Duluth, MN 55812

(218) 726-8155 (218) 726-6132 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

**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
  - ( ) Records regarding treatment for \_\_\_\_\_
  - ( ) Conversations between providers
  - ( ) Immunization Records
  - ( ) Diagnosis / Treatment Plan
  - ( ) Other \_\_\_\_\_
- (Specific Condition or Injury)

**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