AUTHORIZATION TO DISCLOSE INFORMATION

Student Health Center

Lura Manor • Minot State University, 500 University Ave West, Minot, ND 58707
Phone: 701-858-3371/Fax: 701-858-3997

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

Name of Student (Last, First, Middle Initial)	Social Security No.	Birthdate	
Previous Names Used			
Street Address	City	State	Zip Code

STUDENT RELEASE AND SIGNATURE

1. **I Hereby Authorize:**			
Name of Person/Agency	Email Address (only if email delivery is requested)	Telephone Number	
Street Address	City	State	Zip
2. **Permission to:** ☐ Disclose to ☐ Obtain from ☐ Mutually exchange with			
Name of Person/Agency	Email Address (only if email delivery is requested)	Telephone Number	
Street Address	City	State	Zip

3. Provide a detailed description of the information to be disclosed, including how much and what kind of information. (See instructions)

4. The information identified above will be used for: (select all that apply)
   - ☐ Coordination of care/Treatment/Discharge planning
   - ☐ Legal
   - ☐ At the request of the individual
   - ☐ Billing/Payment
   - ☐ Eligibility Determination
   - ☐ Collateral
   - ☐ Other (must specify to be valid):____________________

5. **Authorization remains in effect for one year from the date signed unless a different expiration date is entered here (MM/DD/YYYY):**

STUDENT CONSENT

This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice, at any time except to the extent that action has been taken in reliance on it. Refer to the Department's Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photo copy of this authorization is as effective as the originial.

Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws.

Substance Use Disorder Information is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substane use disorder information.

Signature of student	Date
Signature of witness (if needed)	Date

NOTICE TO RECIPIENTS OF SUBSTANCE USE DISORDER RECORDS: The federal regulations governing the Confidentiality of Substance Use Disorder records, 42 C.F.R. Part 2, prohibits unauthorized disclosure of these records.

DISTRIBUTION: ☐ To agency/person from whom information is sought ☐ Student ☐ Other
☐ Requesting Agency ☐ Student refused copy