CONCORDIA UNIVERSITY
NEBRASKA

# RELEASE OF CONCORDIA HEALTH RECORDS

| Patient's Name *(Please Print)* | Patient Date of Birth | Patient Social Security No. |
|---|---|---|
| Patient Representative's Name *(if applicable)*: *(Please Print)* | Patient Representative's Authority *(e.g., parent, legal guardian)* | |

**I authorize Concordia University to release the following portions of my Student Health record:**

- ☐ Please include any information in my health record regarding my immunization records
- ☐ Please include any information in my health record with the dates of treatment: from _____________to_____________
- ☐ Please include any information in my health record regarding alcohol and substance abuse testing or treatment
- ☐ Please include any information in my health record regarding AIDS-related information, including HIV status
- ☐ Please include any information in my health record regarding my mental health history
- ☐ My entire health record in Student Health, which includes mental health testing and treatment information
- ☐ Additional instructions:

**I hereby authorize and request copies of my medical records from:**

Name:_________________________________________________

Address: ______________________________________________

Phone No.___________________________ Fax No.___________________________

**To be released to:**

Name:_________________________________________________

Address:______________________________________________

Phone No.___________________________ Fax No.___________________________

**Reason for request:** ____Continuity of care *(follow up)* ____Consultation ____Insurance ____School Transfer ____Personal
**Information to be:** ____Mailed ____Picked Up ____Faxed

***I understand and acknowledge that:***

1. My refusal to sign this authorization will not affect my ability to obtain treatment at CUNE.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal law.
3. I have the right to revoke this authorization at any time, provided that I submit my written revocation to Concordia University Student Health Services, Concordia University, 800 No. Columbia Ave, Seward, NE 68434. Any revocation of this authorization does not apply to disclosures already made by Concordia University in reliance on this authorization or for disclosures otherwise required by law.
4. It is possible that the person/entity authorized by my signature to receive the above health record(s) has no duty to protect the confidentiality of records disclosed to them. There is a risk that the recipient may re-disclose the information.
5. I must separately authorize the release of psychotherapy notes.
6. I have read (or had read to me) and have received a copy of this document.
7. This authorization is effective for ________months after the date it was signed.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

| **Patient's or Representative's Signature** | **Date Signed** |
|---|---|
| | |

For Internal Use:

**Witness** **Date** **Records Released by:** **Date:**

_______________________________ _______________________________