

# Mountrail County Health Center

## Authorization for Release of Medical Records

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Record #:** \_\_\_\_\_

- I authorize the use or disclosure of the above named individual's health information as described below.
- The following individual or organization is authorized to make the disclosure:

Address: \_\_\_\_\_  
\_\_\_\_\_

- This information may be disclosed to and used by the following individual or organization:

\_\_\_\_\_  
\_\_\_\_\_

- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

___ Discharge Summary (dates) _____	___ Consultation Report (Dr.'s name) _____
___ History & Physical (dates) _____	___ Physician's Orders (dates) _____
___ Emergency Room Notes (dates) _____	___ Progress Notes (dates) _____
___ Lab Reports (dates) _____	___ Nurses Notes (dates) _____
___ Radiology Reports (dates) _____	___ Other (Specify): _____
___ Medication List _____	_____
___ Immunization Record _____	_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I authorize release of all records pertaining to these conditions: \_\_\_\_\_

(Patient initials)

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_  
If I fail to specify an expiration date, event, or condition, this authorization will expire in one (1) year.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at 701-628-2424.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by Legal Representative, Relationship to Patient

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

Mountrail County Medical Center  
P.O. Box 399  
Stanley, ND 58784  
PH: 701-628-2424  
Fax: 701-628-3823

Mountrail County Rural Health Clinic  
P.O. Box 399  
Stanley, ND 58784  
PH: 701-628-2505  
Fax: 701-628-3823

Mountrail Bethel Home  
P.O. Box 700  
Stanley, ND 58784  
PH: 701-628-2442  
Fax: 701-628-3823

For office use only:

Date:  
Completed By: