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

Mountrail County Health Center

Patient Name:_____**Former Name:**_____
Date of Birth: _____ **Phone:** _____
Address: _____

I authorize:

_____
_____
_____
Phone Fax

To release to my information to:

_____
_____
_____
Phone Fax

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

__ Discharge Summary (dates)_____
__ History & Physical (dates)_____
__ Emergency Room Notes (dates)_____
__ Lab Reports (dates)_____
__ Radiology Reports (dates)_____
__ Medication List

___Clinic Notes (dates) _____
___ Last Year _____
___ Last 3 Years _____
___ Last 5 Years _____
___ Other (Specify):_____
_____

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)

PURPOSE OF THE USE AND DISCLOSURE

____ Further Treatment (Date of Appt.) _____
____ Personal Records
____ Legal
____ Insurance Application
____ Disability Determination
____ Payment of Insurance Claim
____ Other

- 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.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness