

PO Box 399

Stanley, ND 58784

Phone 701-628-2424 (hospital)

Phone 701-628-2505 (clinic)

Fax 701-628-3823

Authorization for Release of Protected Health Information

 **Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Former Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

|  |  |  |
| --- | --- | --- |
| I authorize: |  | To release to my information to: |
|  |  |  |
|  |  |  |
|  |  |  |
| Phone Fax |  | Phone Fax |

**SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED**

\_\_ Discharge Summary (dates)\_\_\_\_\_\_\_\_\_\_ \_\_\_ Radiology Reports (dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ History & Physical (dates)\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Lab Reports (dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Emergency Room Notes (dates)\_\_\_\_\_\_\_ \_\_\_ Last Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Clinic Notes (dates)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the release of records pertaining to**

\_\_\_\_\_ Mental Health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Alcohol and/or Drug Abuse Patient Signature Date

\_\_\_\_\_ HIV/AIDS

**PURPOSE OF THE USE AND DISCLOSURE**

\_\_\_\_ Further Treatment (Date of Appt.) \_\_\_\_\_\_\_\_\_ \_\_\_\_ Insurance

\_\_\_\_ Personal Records \_\_\_\_ Legal

\_\_\_\_ 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.

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Signature of Patient or Legal Representative Date

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

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

*Please allow 5-7 business days for processing*

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