PO Box 399
Stanley, ND 58784
Phone 701-628-2424 (hospital)
Phone 701-628-2505 (clinic)
Fax 701-628-3823

ountrail County Medical Center

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)___________
__ History & Physical (dates)____________
__ Emergency Room Notes (dates)________
__ Clinic Notes (dates)__________________
___ Radiology Reports (dates) ________________
___ Lab Reports (dates) _____________________
___ Last Year ______________________________
___ Other ___________________________________

I authorize the release of records pertaining to
_____ Mental Health
_____ Alcohol and/or Drug Abuse
_____ HIV/AIDS

________________________________ ____________
Patient Signature Date

PURPOSE OF THE USE AND DISCLOSURE

____ Further Treatment (Date of Appt.) __________
____ Personal Records
____ Other
____ Insurance
____ Legal

- 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

Please allow 5-7 business days for processing

MCMC12