Northland Health Centers

1600 2nd Ave SW, Suite 19, Minot, ND 58701
Fax:701.852.4644, Phone: 701.852.4600

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Birthdate _____ Medical Record Number _____

I authorize release of information from:
_____
_____
_____

To be released to:
Alicja, Cebulak, PMHNP-BC
_____
_____

The following information from my medical record for the time period:_____

- ☐ Clinical Resume/Discharge Summary
- ☐ History and Physical Report
- ☐ Consultation Report
- ☐ Operative/Procedure Report
- ☐ Outpatient/ER Report
- ☐ Pathology Report
- ☑ Laboratory Report
- ☐ Radiology Report
- ☑ EKG Report
- ☐ Billing Records
- ☐ Clinic chart notes
- ☐ Immunization Records
- ☐ Physical Therapy Notes
- ☐ V/S's/Medication List
- ☐ Letters
- ☑ Psychiatric/Psychological Evaluation
- ☑ Psychiatric/Psychological Chart Notes
- ☑ Mental Health Chart Notes
- ☑ Mutual Verbal and Written Exchange of Information
- ☑ Other (Please Specify): Genetic Testing

Information to be sent by (please check one):

- ☑ Mail (provide address): _____
- ☐ Pick up (Name of person to pick up records): _____
- ☑ Fax (provide fax numbers): _____
- ☐ I will review the record on-site.

Purpose for request (Check all that apply):

- ☑ Continuing Medical Care
- ☐ Insurance/Billing
- ☐ Military
- ☐ Personal- please specify:_____
- ☐ Legal
- ☐ Other- please specify:_____

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, PRISON RECORD, ALCOHOL, AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.
I specifically authorize the release of the following records:

	Initials		Initials
Psychiatric/Mental Health		Prison Records	
Drug and/or Alcohol Dependency		HIV	

This authorization shall remain in effect until the following date, event or condition: one year from date
If no date, event or condition is specified, this authorization will expire in 3 years in accordance with North Dakota State Law.

If you are the patient's legal representative, describe the scope of your authority to act on the patient's behalf:

- ☑ Parent
- ☐ Durable Power of Attorney for Health Care (attach proof of authority)
- ☐ Legally Authorized Representative (attach proof of authority)
- ☐ Personal Representative of the Estate (attach proof of authority)
- ☐ Other (specify and attach proof of authority) _____

1. This authorization remains in effect until the above date, event or condition, unless specifically revoked by written notice to the Individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. A photocopy of this authorization is as effective as the original.

Signature: Patient over 18 years old or legal representative must sign this form.

_____ _____ _____
(Signature of Patient or Legal Representative) (Relationship) (Date)

☐ By checking this box, I hereby certify that I have personally submitted this data electronically, and that the data contained wihtin is true, complete, and accurate to the best of my knowledge and belief.