Northland Health Centers

15 2nd Ave SW, Suite 110, Minot, ND 58701
Fax:701.838.3097, Phone: 701.838.3051

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____Birthdate _____ Dental Record Number _____

I authorize release of information from: To be released to:

_____ _____

_____ _____

_____ _____

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

- ☐ Dental Resume/Discharge Summary
- ☐ History and Physical Report
- ☐ Consultation Report
- ☐ Operative/Procedure Report
- ☐ Billing Records
- ☐ Dental Chart Notes
- ☐ X-Rays
- ☐ Medication List
- ☐ Letters
- ☐ Other (Please Specify):_____

Information to be sent by (please check one):

- ☐ Mail (provide address):_____
- ☐ Fax or Email:_____
- ☐ Pick up (Name of person to pick up records):_____
- ☐ 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:

This authorization shall remain in effect until the following date, event or condition: _____
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) _____

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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 within is true, complete, and accurate to the best of my knowledge and belief.