



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:

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): _____

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: _____

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