



416 Kundert St, PO Box 535, Turtle Lake, ND 58575

Fax: 701.448.9224, Phone: 701.448.9225

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 dental record for the time period: _____

- | | |
|---------------------------------|-------------------------------|
| Dental Resume/Discharge Summary | Dental Chart Notes |
| History and Physical Report | X-Rays |
| Consultation Report | Medication List |
| Operative/Procedure Report | Letters |
| Billing Records | 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 | Military | Legal |
| Insurance/Billing | Personal- please specify: | 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) _____

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.