First Care Health Center

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Park River, ND 58270
HOSPITAL 701.284.7500 FAX 701.284.4576
RURAL HEALTH CLINIC 701.284.7555 Fax 701.284-7568

Authorization for Release of Protected Health Information

Patient Name: _____ Medical Record Number (Office Use Only): _____
Date of Birth: _____ Patient Address: _____
Phone Number: _____ _____

I authorize: ***To Release Records To:***

Name of organization: _____ _____

Address: _____ _____

City, State, Zip Code: _____ _____

The type and amount of information to be used or released is as follows: (include dates where appropriate)

- ☐ Discharge Summary
- ☐ History and physical
- ☐ Emergency Room record
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Other _____
- ☐ Immunization record
- ☐ Laboratory reports
- ☐ X-ray reports
- ☐ Clinic physician visit notes
- ☐ Billing information
- ☐ Complete record(Hospital or Clinic) Please circle record type needed.
- ☐ X-Ray films

For the following date(s) of treatment or condition: _____

I am requesting this information be released for the following purpose:

_____ Continued care by another provider
_____ Personal use
_____ Attorney review
_____ Patient review
_____ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HTV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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 12 months.

I understand that authorizing the release 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 released, as provided in CFR 164.524.1 understand that any disclosure (release) 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*