First Care HEALTH CENTER
PO Box I / 115 Vivian Street | Park River, ND 58270
HOSPITAL 701-284-7500 FAX 701-284-4576
CLINIC 701-284-7555 FAX 701-284-7568

Authorization for Release of Protected Health Information

Patient Name:_____ MRN# (Office Use Only):_____
Date of Birth: _____ Patient Address: _____
Phone Number: _____ _____

Release Information From: ***Release Information To:***

Name/Facility: _____ _____
Address: _____ _____
City/State/Zip: _____ _____
Phone: _____ _____

Information to be Released (1 year history unless specified):

Service Dates: FROM: _____ **TO:** _____

☐ Progress/Provider Notes ☐ Immunization Record ☐ History and Physical
☐ Emergency Room Record ☐ Laboratory Reports ☐ Billing Information
☐ Discharge Summary ☐ X-Ray Reports ☐ X-Ray Films ☐ X-Ray CDs
☐ PT/OT/SLP Therapy ☐ Operative Reports ☐ Complete record (Hospital or Clinic)
Please circle record type needed.
☐ Other _____ (One year history unless otherwise specified)

Purpose: ☐ Continued Care ☐ Personal Use ☐ Legal ☐ Insurance/Billing ☐ Other _____
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 one year.
Release Format: ☐ Paper ☐ MyChart ☐ Flash Drive (Fees apply) ☐ FAX Number: _____

This information 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. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. 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. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations. A photocopy of this authorization is as effective as the original.

_____ _____
Signature of Patient or Legal Representative *Date*

_____ _____
If signed by Legal Representative, Relationship to Patient *Signature of Witness*