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. Once shared, the records may no longer be protected under the Substance Use Disorder Confidentiality Rule (42 CFR Part 2), but they will still be protected under HIPAA. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients. 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*