Charges apply for hard and digital copies of medical records.

SOUTHWEST HEALTHCARE SERVICES
802 2nd Street NW
Bowman, ND 58623

Date needed by:_____
___To Mail
___To Pick Up

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Information	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City/State/Zip: _____ Maiden/Previous Name(s)/Nickname: _____ Social Security Number: _____
Provider (Who is releasing the information)	Provider/Facility Name: _____ Address: _____ Phone: _____ City/State/Zip: _____
Disclose Information To (Who is releasing the information)	Name/Facility: _____ Doctor/Specialist: _____ Address: _____ Phone: _____ City/State/Zip: _____ Fax: _____
Information To Be Disclosed (Information disclosed also includes information from the patient portal if applicable)	___Lab/EKG/Cardiology Reports ___All Records ___Other (specify below) ___Pathology Reports ___Radiology Reports _____ ___Immunization Records ___Immunization Records ___Clinic Dictate Notes
Purpose of Disclosure (Please be specific)	___Continued Medical Care ___Consult/Second Opinion ___Out of Town Move ___Insurance Claim ___Legal ___Personal ___Other (please specify)_____
Expiration Date	This authorization will expire one year from the date of signature or on:_____
Revocation	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 any 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.
Authorization	I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential of an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. 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 (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and/or drug abuse. _____ _____ Signature of patient/representative Signature/Date _____ _____ (Relationship to patient, if signed by representative) Witness (Optional)
Office Use Only	**FOR OFFICE USE ONLY:** **Date:** _____ **Completed by:** _____ ___**Mailed** ___**Faxed** ___**Picked Up** **Medical Record #:** _____