Charges apply for hard and digital copies of medical records.



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:	dress: Phone:		
	City/State/Zip:			
Disclose Information To (Who is receiving the information)		Doctor/Specialist:		
		Phone:		
	City/State/Zip:		Fax:	
Information To Be Disclosed (Information disclosed	Lab/EKG/Cardiology Reports	All Records	Other (specify below)	
also includes information from the patient portal if applicable)	Pathology Reports	Radiology Reports		
	Immunization Records	_Immunization Records	Clinic Dictate Notes	
Purpose of Disclosure (Please be specific)		Consult/Second Opinio Legal	on Out of Town Move Personal	
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. *Charges apply for hard and digital copies of medical records.*			
	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: MailedFaxedPicked Up			
	Hospital: 701-523-5555 • Fax: 701-523-7104 / Clinic: 701-523-5555 • Fax: 701-523-7126			