6301 19th Ave. NW | PO Box 5007 | Minot, ND 58702-5007
Phone Number | 701.837.6508
Fax Number | 701.837.9953

Release of Information

Patient Name: ______________________________ **Birthdate:** ______________

I authorize: ____
(Hospital, physician agency, or program) (Address, Phone Number or Fax Number)

To release my records to: ____
(Hospital, physician agency, or program) (Address, Phone Number or Fax Number)

I authorize the mutual release of information between the above mentioned parties ____ Yes _____ No

Specific Information To Be Released

This information may be communicated: ___ Verbally ___ Written ___ Fax ___ Other electronic means

____ History and Physical Information, Intake
____ Psychological and Psychiatric Progress and Therapy Notes
____Psychological Testing Results and Psychological Reports
____Chemical Dependency Evaluation and Recommendations ***(youth 14 years and older must consent to release CD records)***
____Discharge Summary
____Other: ____

For the purpose of (check one):
___Referral or Consult ___Insurance Company or Disability Claim ___Transfer of care ___Attorney or Legal Matter
___Coordination of Care ___Other, (Please specify,______________________________)

This information above will be used for assessment and treatment of client.

The release remains in effect until _____/_____/_____, unless revoked by me.
The release remains in effect until the above date unless specifically revoked by written notice to the agency of person. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this release is as effective as the original.

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicate otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive or release the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and cannot be re-disclosed. I understand that my health care will not be affected if I do not sign this form.

Signature of Patient: ______________________________ Date: ____________

Signature of Parent (if needed): ______________________________ Date: ____________

Signature of Legal Custodian (if needed): ______________________________ Date: ____________

Signature of Witness (if needed): ______________________________ Date: ____________

Notice to Whomever Disclosure is Made Concerning Records: This information has been disclosed to you and you alone from medical records whose confidentiality is protected by Federal Law and is being released on the basis that responsibility for any legal liability from such.

NOTICE TO WHOMEVER DISCLOSURE IS MADE: THIS INFORMATION HAS BEEN DOSCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42-CFR PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIED WRITTEN CONSENT OF THE PERSON WHOM IT PERTAINS OR OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION IS **NOT** SUFFICIENT.