

RELEASE OF PATIENT MEDICAL INFORMATION

Patient Name

Patient's Date of Birth Phone Number

REQUESTED FROM:

TO BE RELEASED TO:

Name of Clinic or Physician

Name of Clinic or Physician

Address

Address

City, State Zip Code

City, State Zip Code

Phone Fax

Phone Fax

PURPOSE OF THIS REQUEST:

DATE NEEDED BY: _____

Personal use **Legal**
 Insurance **Military** **Other (Please specify)** _____
 Continued Medical Care **School**

Information to be released:

Last 2 years medical history **Other (Please be specific)** _____

**Records of a sensitive nature will not be released unless specifically authorized below.
Any patients 14 years or older must authorize the release of their own sensitive information.**

Psychiatric/Mental/Chemical Dependency	_____	Initial	_____	Date
HIV	_____	Initial	_____	Date
Contraception/STD	_____	Initial	_____	Date

I understand that if records are released to someone who is not a healthcare provider, health plan, or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may be further disclosed without obtaining my authorization.

I understated that I have a right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form by contacting Medical Records Department.

I understand that if I sign this authorization, I have a right to receive a copy of this form if requested.

I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature. However, our medical treatment of the patient is not condition on the signing or failure to sign this form. This authorization is effective for one year unless otherwise specified as follows: _____

I understand I may cancel this authorization at any time by written notification. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the Medical Records Department.

I have had an opportunity to review and understand the contents of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes. I release the staff of Center for Family Medicine from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

Signature of Patient or Legal Representative

Date

If not present, state relationship-proof may be required

Witness

3/07

University of North Dakota School of Medicine and Health Sciences

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IN RURAL HEALTH



1905