Authorization for Release of Information

Dakota Regional Medical Center
107 12th Street South
Cooperstown, ND 58425
Telephone: 701-786-1700

****ROI FAX #: 1-701-786-7121****

MRN: _____

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

City/ State/ Zip: _____ **Maiden/Previous Names:** _____

Release Information From:

Name/Facility:
Address:
City/State/Zip
Phone: Fax:

Release Information To:

Name/Facility:
Address:
City/State/Zip
Phone: Fax:

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING. (I specifically authorize the release of the following:)

☐ Psychiatric/Psychological _____ Initials ☐ HIV _____ Initials ☐ Drug and/or Alcohol Dependency _____ Initials

☐ **Two-Way** ongoing written/verbal for the above information

☐ **Notice to Whomever Disclosure is made concerning addiction records:**
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. Once shared, the records may no longer be protected under the Substance Use Disorder Confidentiality Rule (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.

Information to be Released:

☐ Provider Notes
☐ H&P Admission
☐ Discharge Summary
☐ Billing Information
☐ PT/OT/SLP Therapy
☐ Immunization Record
☐ Emergency Room Record
☐ Current Medication List
☐ Advance Directives
☐ Allergy Records
☐ X-ray Reports ☐ X-ray Films/CD
☐ Laboratory Reports
☐ Other _____
☐ Complete record *(One year history unless otherwise specified below.)*

☐ For the following date(s) of treatment or condition: _____

Purpose: ☐ Continued care ☐ Legal ☐ Disability ☐ Personal use ☐ Insurance/ Billing
☐ Worker's Comp ☐ Military ☐ Wellness ☐ 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: ___ FAX ___ My Health ___ Paper ___USB ___Oral ____ Email* I acknowledge that I have been informed that email is not encrypted and can be intercepted. **Initial**: _____
Email Address: _____

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. 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 re-disclosed and no longer protected by this federal regulation. A photocopy of this authorization is a effective as the original. **If not previously revoked, this authorization will expire in 12 months.**

Signature (required) _____ **Date Signed (required)** _____

Printed Name of Person Signing (if not patient) _____ **Relationship of Person Signing (if not patient)** _____

2 Person Verbal (DRMC Staff) (if Patient Physically UNABLE)

_____ _____