Authorization for Release of Information

Name of Patient: (print) _____ **DOB:** _____

DRMC MR #: _____

I Authorize:

_____
_____
_____
FAX #:
PHONE #:

To Release To:

_____
_____
_____
FAX #:
PHONE #:

Information to be Disclosed:
(1 year history unless specified)

❒ DRMC Treatment from **(Date Of Service):** _____

❒ Hospital Admission Summary
❒ Hospital Discharge Summary
❒ Operative Report
❒ Psychiatric Intake
❒ Psychiatric Interim
❒ Verbal and/or written exchange about my medical information
❒ Acknowledgement of my past and/or current admission as a patient in the facility
❒ Verbal Discussion Only – Do NOT Disclose Written Information
❒ Other (please specify): _____

❒ Lab Reports
❒ Progress Notes
❒ X-Ray Report
❒ X-Ray Films

OR:
❒ Entire Medical Record

I AUTHORIZE THE RELEASE OF ALL ALCOHOL, AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:

❒ Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

Purpose of the Use and Disclosure:

❒ Further Treatment **(Date of Appointment** _____**)**
❒ Insurance Application
❒ Disability Determination
❒ Vocational Rehabilitation Evaluation
❒ Other (please specify): _____

❒ Legal
❒ Personal Records
❒ Education
❒ Payment of Insurance Claims

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 indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment of my health care will not be affected if I do not sign this form.

I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. **If not previously revoked, this authorization will expire in 12 months.**

A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Patient/Guardian Representative Date

_____
If not patient, state authority/relationship

Dakota Regional Medical Center
107 12th Street South
Cooperstown, ND 58425
Telephone: 701.786.1700
******ROI FAX #: 1-701-786.7122******

OFFICE USE ONLY:

Verbal Authorization: 1._____ Date _____

2._____ Date _____

COMPLETED BY:_____

DATE: _____

Revised: 5/2024/dmn
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