



AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY

Patient's Name _____ Date of Birth _____

Social Security Number _____ Telephone Number _____

Purpose of this request: _____

I authorize Mid Dakota Clinic to give information when requested to (list relationship):

Type of information to be released: Medical _____ Billing _____

Based on this release, billing information may be given verbally or in printed form. Medical information will be verbal only. I understand that when my information is released as a result of this release, it is no longer protected by the federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- I understand that I have the right to inspect or receive a copy of the health information I have authorized to be disclosed by this authorization form by contacting the Record Information Nurse at 530-6361.
- I understand that 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.
- This release is valid for as long as I am a patient of Mid Dakota Clinic unless revoked by me. I understand that I may cancel this authorization at any time by written notification. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Records Information Nurse at 530-6361. I am aware that my withdrawal will not be effective for disclosures of my information that Mid Dakota Clinic has previously made.

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 Mid Dakota Clinic PrimeCare from all liability pertaining to disclosure of any medical and billing information in association with this release.

Signature _____ Date _____

Information that is of a sensitive nature will not be released without specific authorization. Any patient 14 years of age or older must authorize the release of their own sensitive information.

Please release the following sensitive information:

Mental Health/Chemical Dependency _____ Date _____

HIV/AIDS related illness or testing _____ Date _____

Contraception/STD's (if ages 14-17) _____ Date _____

Witness _____ Date _____