



AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY

Patient's Name _____ Date of Birth _____

Soc. Sec. No. _____ Telephone No. _____

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 authorization 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 requested 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 authorization is effective for one year unless otherwise specified as follows: _____.

I understand that I may cancel this authorization at any time by written notification. To obtain information on how to withdraw my authorization, 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 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/STDs (if ages 14-17) _____ Date _____

Witness: _____ Date _____