MID DAKOTA CLINIC
The doctors you know and trust.℠

PO Box 5538
Bismarck, ND 58506
Phone: 701.712.4099 Fax: 701.712.4097

Authorization for Disclosure of Protected Health Information

Name: _____ Maiden/Other Name: _____

Date of Birth: _____ Phone: _____

Release of Information From:	**Release of Information To:**
Name/Facility: _____	Name/Facility: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone/Fax: _____	Phone/Fax: _____

Purpose of this Request: _____ **Date Needed by:** _____

Information to be Released Dates of Service From _____ To _____. (If no date marked, 1 year of records will be sent)

☐ Clinic Notes/Consults/History and Physical ☐ Labs ☐ Radiology Reports ☐ Immunizations

☐ Operative/Pathology Reports ☐ Other: _____

Records of a sensitive nature will not be released unless specifically authorized below. Release of psychotherapy notes must be approved by the authorizing provider. Any patients 14 years or older must authorize the release of their own sensitive information.

Substance Use Disorder/Chemical Dependency _____ Date _____

Contraception/STDs (if ages 14-17) _____ Date _____

Psychiatric/Mental Health/Psychotherapy Notes* _____ Date _____

**Release Authorized by* _____ *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 understand that I have the 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 the Release of Information 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 conditional 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. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that may have already been released. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the Release of Information Department.

I understand that Mid Dakota Clinic will not receive payment in connection with the use or disclosure of my health information, unless specified here: _____. This does not apply to a reasonable fee for copying and mailing when releasing records directly to the patient. There is no charge if medical records are released to a physician, hospital, clinic, or other medical facility for continued care purposes.

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 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**

PLEASE READ INFORMATION ON BACK

If this request is for the purpose of continuing medical care, we will attempt to process the request within 72 hours. Allow up to 30 days for all other requests, including legal, personal, and applications for life, health, and disability insurance.

The charges for the release of medical records:

1. There is no charge if medical records are released directly to a physician, hospital, clinic, or other medical facility for continued care purposes.
2. There is no charge if a medical facility specifically requests that you hand carry your medical records and your Mid Dakota Clinic physician knows you are going to another medical facility.
3. There will be a nominal fee charged to the patient when records are released directly to them.