MID DAKOTA CLINIC
The doctors you know and trust.℠

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: Verbal: Medical _____ Billing_____

Portal: Full Access _____ 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 Release of Records Department at 701.712.4099.
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 Release of Records Department at 701.712.4099. 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_____