Northland Health Centers

Fax:701.477.6342, Phone: 701.477.3111

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____Birthdate _____ Medical Record Number _____

I authorize release of information from:
Facility Name:_____
Address:_____
City, State, Zip:_____
Phone:_____

To be released to:
Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
E-Mail:_____

The following information from my medical record for the time period:_____

- ☐ Clinic Visit Notes
- ☐ Immunization Record
- ☐ Laboratory Reports(s)
- ☐ Radiology Report(s)
- ☐ Substance Use Disorder Records
- ☐ Mutual Verbal & Written Exchange of Information
- ☐ Mental Health Records
- ☐ Billings Records
- ☐ **Psychiatric & Psychological Evaluations, Assessments, Testing, Notes, Medication, and Diagnosis**
- ☐ **Other (Please Specify):**_____

Information to be sent by (please check one): ☐ Mail ☐ Email ☐ Fax (number): _____ ☐ Pick up (Name): _____

Purpose for request (Check all that apply): ☐ Continuing Medical Care ☐ Military ☐ Legal ☐ Insurance/Billing
☐ Personal (Please Specify):_____ ☐ Other (Please Specify):_____

This authorization shall remain in effect until the following date, event or condition: _____
If no date, event or condition is specified, this authorization will expire in 3 years in accordance with North Dakota State Law.

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, PRISON RECORD, ALCOHOL, AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.
I specifically authorize the release of the following records:

	Initials		Initials
Psychiatric/Mental Health		Prison Records	
Drug and/or Alcohol Dependency		HIV	

1. This authorization remains in effect until the above date, event or condition, unless specifically revoked by written notice to the Individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. A photocopy of this authorization is as effective as the original.
5. SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations.
6. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.
7. NOTICE TO RECIPIENTS OF SUBSTANCE USE DISORDER RECORDS:
   The federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

Signature: Patient over 18 years old or legal representative must sign this form.

_____ _____ _____
(Signature of Patient or Legal Representative) (Relationship or Scope of Authority) (Attach Proof of Authority) (Date)

Verbal confirmation given by patient to NHC staff for release of information_____

☐ By checking this box, I hereby certify that I have personally submitted this data electronically, and that the data contained within is true, complete, and accurate to the best of my knowledge and belief.