AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT ____
(FIRST) (MIDDLE) (LAST) (MAIDEN OR OTHER NAMES USED)

DATE OF BIRTH ______________________ **PHONE NUMBER** ______________________
(MONTH) (DAY) (YEAR)

PATIENT ADDRESS ____

RELEASE TO/OBTAIN FROM (circle one)

Spectra Health
212 S 4th St Ste. 200
Grand Forks, ND 58201-4776

Medical/Dental PH# 701-757-2100
Medical Fax# 701-757-0305 Dental Fax# 701-757-2103

BHC - For Future Use or Verbal Consent Only.

RELEASE TO/OBTAIN FROM (circle one)

____
(Name of Health Care Provider/Plan/Other)

____
(Address)

______________ ______________ ______________
(Phone Number) (Fax Number) (Email Address)

The information may be communicated in the following manner:
________Verbal________Written________Electronic

INFORMATION TO BE DISCLOSED (Check Applicable Categories)

- ____ General Release (last 2 years)
- ____ Specific Time Period Release: From _______ To ________
- ____ Obstetrical Records
- ____ Immunization Records
- ____ Consultation Reports
- ____ X-Ray Reports – Specify______________________
- ____ Lab Reports – Specify ______________________
- ____ Other: ______________________

In compliance with ND Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

- ____ Mental Health/Psychiatric
- ____ HIV/AID/AIDS Related Illness
- ____ Other:______________________
- ____ Drug/Alcohol Dependency
- ____ Sexually Transmitted Disease

INFORMATION TO BE DISCLOSED (Check Applicable Categories)

- ____ Further Medical Health Care
- ____ Further Dental Health Care
- ____ Further Behavioral Health Care
- ____ Other:______________________
- ____ Insurance Eligibility/Benefits
- ____ Changing Physicians
- ____ Legal Investigation or Action
- ____ Personal

I understand that if the person(s) and /or organization(s) listed above are not a health care provider, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of the authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Spectra Health Medical Records Department at 701-343-6418 ext. 2102.

Right to Receive Copy of This Authorization – I understand that If I agree to sign this authorization, which I am not required to, I must be provided with a signed copy of the form.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Spectra Health Medical Records Department at 701-343-6418 ext. 2102. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made about this authorization.

Expiration Date - This authorization is good for one year from the signed date, unless otherwise specified.

PATIENT SIGNATURE:______________________ **DATE**__________ **RELATIONSHIP TO PATIENT**______________

If signed by other than patient, state relationship and Authority to do so.

Requested Provider: ______________ Sender Initials: ________

Date Sent: ______________ FAX/MAIL