Authorization for Disclosure of Protected Health Information

212 S 4th St Ste 200
Grand Forks, ND 58201
Records Phone (701) 757-2810
Records Fax (701) 757-2811
Records@SpectraHealth.org

Name:_____ Date of Birth:_____

Street Address:_____ _____
(Maiden/Other Names Used)

City, State, Zip:_____

Phone Number:_____ Email:_____

THIS FORM AUTHORIZES SPECTRA HEALTH TO (Mark up to 2 categories)**:**

☐ **RELEASE RECORDS TO:**

OR

☐ **OBTAIN RECORDS FROM:**

_____
Name of Healthcare Provider/Other

_____
Street Address

_____
City, State, Zip

_____ _____
Phone Fax

☐ **SELECT TO MUTUALLY EXCHANGE INFORMATION**

INFORMATION TO BE DISCLOSED (Mark all applicable categories)**:**

☐ General Release (last 2 years)
☐ Specific Time Period Release: From_____ To_____
☐ Immunization Records
☐ Optometry Records
☐ Other:_____
☐ Obstetrical Records
☐ Consultation Reports
☐ X-Ray Reports
☐ Lab Reports
☐ ***Drug/Alcohol Dependency**
☐ Mental Health/Psychiatric
☐ Sexually Transmitted Disease
☐ HIV/AIDS Related Illness

***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.** 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.

PURPOSE FOR DISCLOSURE (Mark all applicable categories)**:**

☐ Continuing Medical Care
☐ Continuing Behavioral Health Care
☐ Personal
☐ Other:_____
☐ Insurance Eligibility
☐ Changing Physicians
☐ Legal Investigation

NOTICE: records released directly to the patient or patient's representative for personal use may incur additional charges, see reference sheet for more information

I understand that if the person(s) and/or organization(s) listed above are not health care providers, 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 Clinical Records Department at (701) 757-2810.

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's Health Information Management Department at (701) 757-2810. 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 here_____

SIGNATURE_____ DATE_____ Relationship to Patient_____

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

Requesting Provider:_____ Sender Initials:_____

Date Sent:_____ FAX/MAIL

PATIENT LABEL HERE