



Authorization for Disclosure of Protected Health Information

212 S 4th St Ste 200
Grand Forks, ND 58201
Clinic Phone (701) 757-2100
Records Phone (701) 757-2810
Records Fax (701) 757-2811
Records@SpectraHealth.org

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

City, State, Zip: _____

Email: _____

THIS FORM AUTHORIZES SPECTRA HEALTH TO:

☐ RELEASE HEALTH RECORDS TO

OR

☐ OBTAIN HEALTH RECORDS FROM

☐ SELECT TO MUTUALLY EXCHANGE HEALTH RECORDS

Name of Outside Organization

Street Address

Phone

Fax

Email

INFORMATION TO BE DISCLOSED (mark all applicable categories):

☐ General Time Period Release: _____ To _____

☐ Lab Reports

☐ X-Ray Reports

☐ Immunization Records

☐ STD/HIV/AIDS Related Illness

☐ History of Alcohol/Drug Usage and Behavior

☐ Behavioral Health Progress Notes

☐ Behavioral Health Treatment Dates and Discharge Status

☐ Results of Addiction Evaluation and Recommendations

☐ Other (specify) _____

PURPOSE FOR DISCLOSURE (mark all applicable categories):

☐ Continuing Medical Care

☐ Continuing Behavioral Health Care

☐ Collateral Information

☐ Social Services Support

☐ Insurance Investigation

☐ Other (specify) _____

Spectra Health acknowledges that the provision of the services is not contingent upon the client's decision concerning the release of this information. This consent is subject to revocation at anytime except to the extent that the program which is to make the disclosure has already taken action in reliance on it. A copy of this release is as effective as the original. **This authorization is valid for one year from the date signed if not previously revoked or otherwise specified here:** _____

Signature of Patient

Date

Signature of Guardian or Authorized Representative

Date

Witness

Date

In accordance with North Dakota state law, minor patients over the age of 14 must sign this disclosure and consent to the release of their protected substance use disorder treatment information.

SUBSTANCE USE DISORDER TREATMENT INFORMATION: Complete this section if you want to authorize the disclosure of any Substance Use Disorder Treatment information. If this section is not completed, any records referencing Substance Use Disorder Treatment information may not be disclosed.

☐ By checking this box, I authorize the disclosure of my Substance Use Disorder Treatment information contained in the information selected or described in this authorization

NOTICE TO WHOEVER DISCLOSURE IS MADE: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2. (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).