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Tioga Medical Center Hospital/Clinic

Phone: 701-664-3305 option 2

**Fax: 701-664-2646**

P.O. Box 159

Tioga, ND 58852

**Authorization for Release of Medical/Confidential Information**

|  |  |
| --- | --- |
| Patient Name (Last, first, middle initial) | Date of birth |
| Address | City | State | Zip |

**Release From:**

Facility: **Appointment Date:**

Phone Number : Fax Number :

Address:

**Release To:**

Facility: **Appointment Date:**

Phone Number : Fax Number :

Address:

**Dates of Services you are requesting records for From: To:**

**This information is being requested for the purpose of:**

**\_\_\_\_\_** Coordination of Services \_\_\_\_\_ Establishing care \_\_\_\_\_ Legal Proceedings

\_\_\_\_\_ Follow-up treatment \_\_\_\_\_ Referral \_\_\_\_\_ Other:

**The following written and/or verbal information may be disclosed:**

\_\_\_\_\_ Emergency Room Record \_\_\_\_\_ Physician Orders \_\_\_\_\_ Nurses Notes

\_\_\_\_\_ History & Physical \_\_\_\_\_ Laboratory Reports \_\_\_\_\_ Progress Notes

\_\_\_\_\_ Discharge Summary \_\_\_\_\_ Radiology Reports \_\_\_\_\_Clinic Notes \_\_\_\_\_ Consultation Reports \_\_\_\_\_ ECG/EEG Reports \_\_\_\_\_ Other:

Records given

Number of Pages

Initials

**I authorize release of records pertaining to:** (NOTE: for addiction services, 14-years-old and older is considered an adult.)
 \_\_\_\_\_ Mental Health/psychiatric diagnosis/treatment \_\_\_\_\_ Alcohol and/or Drug Abuse
 \_\_\_\_\_ HIV Testing/Aids/Aid related illnesses \_\_\_\_\_Diagnosis/treatment of sexually transmitted disease(s)

**Patient Signature:**

**This release of information authorization remains in effect for six (6) months from the date of this consent unless otherwise noted**

|  |  |
| --- | --- |
| Signature of Patient | Date |
| Signature of Parent, Guardian or Authorized Representative (if needed) | Date |
| Signature of Witness | Date |

I understand that I have the right to revoke this authorization at any time by giving written notice to the Tioga Medical Center Health Information Department. I understand that this authorization will remain in effect until the above date unless specifically revoked by me. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Tioga Medical Center Privacy Officer. Lastly, I understand that a photocopy of this release is as effective as the original.