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	Records given ☐
_____ History & Physical	_____ Laboratory Reports	_____ Progress Notes	Number of Pages _____
_____ Discharge Summary	_____ Radiology Reports	_____ Clinic Notes	
_____ Consultation Reports	_____ ECG/EEG Reports	_____ Other:	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

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.

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