

St. Joseph's Hospital and Health Center

30 West Seventh Street
Dickinson, ND 58601-4399
Telephone: 701-456-4268
FAX: 701-456-3822

For Internal Use ONLY
Date: _____ MR# _____
Completed by: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Birth Date: _____

Other Name (Maiden Name): _____

Home Phone #: _____

Address: _____

Other Phone #: _____

I authorize release of my medical information from: St. Joseph's Hospital & Health Center or
[] Badland's ENT
[] Beach Medical Clinic
[] Dakota Bone and Joint
[] Killdeer Medical Clinic
[] Other _____
To be released to:
Name: _____
Phone #: _____
[] Mail to: _____
[] Fax to: (_____) _____
[] Will pickup on this date: _____

The following health information from these dates of treatment may be released: _____

Check (✓) all that apply:

- Outpatient Clinic Notes Emergency Report EKG OT/PT Rehab Records
Discharge Summary Operative/Pathology Laboratory Billing Statements
History and Physical Radiology Report Stress Test Other (Specify):
Consultation Report Radiology Film Holter Test

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions unless checked here and initialed: [] I do not authorize release of this type of information. _____ Initials

Purpose for the use and/or disclosure of the information:

- [] Diagnosis and Treatment [] Insurance/Billing [] Legal [] Personal

*I understand a fee may be charged for copies of my medical record.

- St. Joseph's Hospital & Health Center will not condition treatment on your signing this authorization, unless you are receiving research-related treatment; or the only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).
I understand that the information used and/or disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by the federal privacy law (also known as HIPAA). However, under Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.
I understand that I may revoke this authorization at any time by completing the Revocation of Authorization form. Revocation will not affect any actions that St. Joseph's Hospital & Health Center took before it received my revocation letter. A photocopy of this release is as effective as the original.

This authorization will expire in 1 year unless otherwise specified _____

Signature of Individual or Personal Representative

Date

If Patient is unable to sign, please state relationship to patient and reason for signing.