Instructions for obtaining Medical Records

Your medical records are an important part of your continuing health care. You have the right to request copies, either for your own use in managing your health information or for your physicians use when transferring care to another facility.

Requesting records to be sent to another physician office of your choice is free of charge. If you are requesting records for your own personal use, there may be a fee in which you will be notified of this prior to copies made.

**How to request your medical records:**

1. Print [authorization form](http://www.sanfordhealth.org/content/pdfs/ReleaseOfInformation/ROI_Authorization_Form.pdf?v=3) (below).
2. Fill out the form as complete as possible
   * Include both the name and address that you would like your records released to or obtained from
   * Be as specific as you can about the information that you would like released or obtained (e.g., specific dates of service, specific treatment, immunizations only, etc.)
3. Completed forms can be dropped off at any Family HealthCare location, mailed or faxed (see address and fax number below). We do not accept email or online submissions.

**Mailing address:**

Family Healthcare

Health Information

301 NP Avenue

Fargo, ND 58102

**Phone:** (701) 271-3344

**Fax:** (701) 271-3347

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION



301 NP Ave Fargo ND 58102

Phone (701) 271-3344

Fax (701) 271-3347

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| Patient Name | |  | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | |
|  | | Last | | | | | | | First | | | | | Middle | | | | | | | | | | | (Maiden or other Names Used) | | | | | | | |
| Patient Address | | |  | | | | | | | | | | | | | | |  | Date of Birth | | | | | | | | |  | | | | |
|  | | |  | | | | | | | | | | | | | | |  | Social Security No. | | | | | | | | |  | | | | |
| Phone Number | | |  | | | | | | | | | | | | | | |  | **FHC #** | | | | | | | | |  | | | | |
| **AUTHORIZES FAMILY HEALTHCARE TO RELEASE TO:** | | | | | | | | | | | | | | | |  | **AUTHORIZES FAMILY HEALTHCARE TO OBTAIN FROM:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | |
| Name of Health Care Provider/Other | | | | | | | | | | | | | | | |  | Name of Health Care Provider/Other | | | | | | | | | | | | | | | |
| Street Address | | | | | | | | | | | | | | | |  | Street Address | | | | | | | | | | | | | | | |
| City, State, Zip Code | | | | | | | | | | | | | | | |  | City, State, Zip Code | | | | | | | | | | | | | | | |
| ***Place* 🞭 *in the appropriate boxes*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Information to be disclosed: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 🞏 | General Release (last 2 years) | | | | | | | | | | 🞏 | | Specific Release time period | | | | | | | | | | | | | | From | |  | | To |  |
| 🞏 | Obstetrical Records | | | | | | | | | | 🞏 | | X-ray Reports (Specify) | | | | | | | | | | | | |  | | | | | | |
| 🞏 | Immunization Records | | | | | | | | | | 🞎 | | Consultation Reports | | | | | | | | | | |  | | | | | | | | |
| 🞏 | Lab Reports (Specify) | | | | |  | | | | | 🞏 | | Other (Specify) | | | | | | | |  | | | | | | | | | | | |
| All records pertaining to Mental Health, Chemical Dependency, will not be released unless specifically authorized below in writing.\*   * Mental Health   Initials Date     * Chemical Dependency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Initials Date Signature of Patient 14 years and older  \* This information is protected by federal law (42 CFR, Section 2), which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information in **Not Sufficient** for this purpose. \* **Signature needed for Chemical Dependency records of patients 14 years and older.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Records needed for: | | | | 🞏 | Personal | | 🞏 | | | Legal | | 🞏 | | | Insurance | | | | | 🞏 | | Healthcare, Appt on: | | | | | | | |  | | |
|  | | | | 🞏 | Other (specify) | | |  | | | | | | | | | | | | | | | | | | | | | | | | |

Note: We will not re-disclose records from other facilities unless specifically specified on the release.

**Expiration Date of Authorization**: This authorization is effective through \_\_\_\_/\_\_\_\_/\_\_\_\_ unless revoked or terminated by my personal representative or me. If no date is indicated, authorization will remain in effect for one year from the signature date, and will automatically expire without my revocation.

**Right to Terminate or Revoke Authorization**: You may revoke or terminate this authorization by submitting a written revocation to Family HealthCare Center.

**Potential for Re-disclosure**: Information being disclosed to other health care provides for continuum of care may include information received from other healthcare entities with the exception of Mental Health or Chemical Dependency notes. The privacy of this information may not be protected under the federal privacy regulations.

I understand that any release that was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining an individual’s authorization. I direct that a photocopy or FAX copy of this authorization be granted the same authority as the original.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Signature of Patient/Parent/Guardian |  | Date |  | Witness |

(\* If patient is a minor, parent/guardian **MUST** sign unless patient emancipated) (\* Adults **MUST** sign for themselves unless incapacitated)

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| **CLINIC**  **EMPLOYEES**  **ONLY** | **Charges**: | |  |  |  |
| **No charge**/1-10 pages  **$15**/11-24 pages | |  |  |  |
| **$20**/25 pages  **$0.75**/each add’l page  Faxed by: Date: |  | |  |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 🞏 | Parent of Minor | 🞏 | | Legal Guardian | 🞏 | Next of Kin | 🞏 | Power of Attorney  of Healthcare |
| 🞏 | ID Shown: | |  | | |

Legal authority if signed by person other than patient (proof required):

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