FAMILY HealthCare
301 NP Ave Fargo ND 58102
Phone (701) 271-3344
Fax (701) 271-3347

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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:

Name of Health Care Provider/Other
Street Address
City, State, Zip Code
Email or Fax Number

AUTHORIZES FAMILY HEALTHCARE TO OBTAIN FROM:

Name of Health Care Provider/Other
Street Address
City, State, Zip Code

Place ✖ in the appropriate boxes

Information to be disclosed:

- ☐ General Release (last 2 years)
- ☐ Obstetrical Records
- ☐ Immunization Records
- ☐ Specific Time Period Requested → From: To:
- ☐ Dental
- ☐ X-ray/Imaging Reports
- ☐ Lab Reports (Specify):
- ☐ Drug/Alcohol Treatment
- ☐ Mental Health
- ☐ Consultation Reports
- ☐ Other (Specify):

I authorize the release of all mental health and drug and/or alcohol treatment records that are part of the records specified above unless indicated here:

_____ Do not release drug or alcohol treatment records protected under federal law (42CFR, Section 2)
Initials

_____ Do not release mental health records protected under federal law (42CFR, Section 2)
Initials

Records needed for: ☐ Personal ☐ Legal ☐ Insurance ☐ Healthcare, Appt on: _____
☐ Other (specify) _____

Note: We will not re-disclose records obtained from other facilities.

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 providers for the continuum of care may include information received from other healthcare entities except for 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)

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:

☐ 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):