



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

Phone Number

Date of Birth

Social Security No.

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

 Email or Fax Number

Place ✕ in the appropriate boxes

Information to be disclosed:

- | | | |
|---|---|---|
| <input type="checkbox"/> General Release (last 2 years) | <input type="checkbox"/> Dental | <input type="checkbox"/> Drug/Alcohol Treatment |
| <input type="checkbox"/> Obstetrical Records | <input type="checkbox"/> X-ray/Imaging Reports | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Lab Reports (Specify): | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Specific Time Period Requested → From: _____ To: _____ | | <input type="checkbox"/> 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: _____

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Parent of
Minor | <input type="checkbox"/> Legal
Guardian | <input type="checkbox"/> Next of
Kin | <input type="checkbox"/> Power of Attorney
of Healthcare |
| <input type="checkbox"/> ID Shown: | | | |

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