FAMILY HealthCare

301 NP Ave Fargo ND 58102 | Fax (701) 271-3347 | Phone (701) 271-3344 | Email: MedRec@famhealthcare.org

Authorization for Release of Information

Patient Name _____ _____ _____ _____
Last First Middle (Maiden or other Names Used)

Patient Address _____ Date of Birth _____

_____ Patient Email _____

Phone Number _____ MRN _____

I authorize Family HealthCare to: ☐ Request from ☐ Send to ☐ Mutually Exchange with

_____
Name of Health Care Provider/Other

_____
Street Address

_____ _____
City, State, Zip Code Email Address

_____ _____
Phone # Fax #

Purpose of Release ☐ Personal (*charges may apply*) ☐ Legal ☐ Insurance ☐ Disability Determination ☐ Continuity of Care

☐ Other: _____

Release Format ◯ MyChart Portal ◯ Fax to number above ◯ Secure email to address above
(Check only 1 option) ◯ Paper via USPS Mail to address above ◯ Pick Up at FHC Downtown location (fee may apply)

Personal use when printed will be charged for pages over 25 pages of $20 + PLUS $0.75 each add'l page

Place ✖ in the appropriate boxes

Information to be released **includes ALL** mental health and drug/alcohol treatment unless specified below:

☐ General Release (last 2 years)	☐ Specific Dates FROM: ___ TO: ___	
☐ Progress Notes	☐ Dental	☐ Drug/Alcohol Treatment
☐ Obstetrical Records	☐ X-ray/Imaging Reports	☐ Mental Health
☐ Immunization Records	☐ Lab Reports (Specify):	☐ Consultation Reports
☐ Billing Statements	☐ Other:	

By signing this document, I authorize the release of all Alcohol and/or Drug treatment records that are part of the records I specified above unless otherwise indicated below:

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

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

****This authorization expires one year from the date of my signature unless I specify a different expiration date here:** _____

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Printed Name of Signature (If not Patient) Relationship of Person Signing

_____
Witness Name and Title

*Must have legal authority if signed by a person other than patient and proof of ID required.