Center for Family Medicine
Bismarck UND

Center for Family Medicine
701 E. Rosser Ave.
Bismarck, ND 58501
(701) 751-9500
Fax (701) 751-9508

RELEASE OF PATIENT MEDICAL INFORMATION

Patient Name ____________________ Patient's Date of Birth ____________ Phone Number ____________

REQUESTED FROM:

Name of Clinic or Physician

Address

City, State Zip Code

Phone Fax

TO BE RELEASED TO:

Name of Clinic or Physician

Address

City, State Zip Code

Phone Fax

PURPOSE OF THIS REQUEST:

__ Personal use
___Insurance
___Continued Medical Care
___Legal
___Military
___School
____Other (Please specify) ______________________________

DATE NEEDED BY: ______________

Information to be released:

_____Last 2 years medical history ____Other (Please be specific)______________________________

Records of a sensitive nature will not be released unless specifically authorized below.
Any patients 14 years or older must authorize the release of their own sensitive information.

Psychiatric/Mental/Chemical Dependency	__________Initial	__________Date
HIV	__________Initial	__________Date
Contraception/STD	__________Initial	__________Date
Pain Management File	__________Initial	__________Date

I understand that if records are released to someone who is not a healthcare provider, health plan, or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may a be further disclosed without obtaining my authorization.
I understated that I have a right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form by contacting Medical Records Department.
I understand that if I sign this authorization, I have a right to receive a copy of this form if requested.
I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature. However, our medical treatment of the patient is not condition on the signing or failure to sign this form. This authorization is effective for one year unless otherwise specified as follows: ______________________________.
I understand I may cancel this authorization at any time by written notification. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the Medical Records Department.
I have had an opportunity to review and understand the contents of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes. I release the staff of Center for Family Medicine from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

Signature of Patient or Legal Representative ____________________ Date ____________

If not present, state relationship-proof may be required ____________________ Witness ____________

THE NATION'S LEADER IN RURAL HEALTH
University of North Dakota School of Medicine and Health Sciences
UND is an equal opportunity / affirmative action institution
1905