WEST RIVER
HEALTH SERVICES
1000 HIGHWAY 12 · HETTINGER, ND 58639-7530 · 701-567-4561
Fax: 701-567-6364

AUTHORIZATION FOR RELEASE OF INFORMATION

Appointment Date:__________________

1. Printed Patient Name:__________________ Maiden/Former Name:__________________

   Birth Date:__________________ MR #:__________________ **(Office Use Only)**

   Street Address:__________________

   City, State, Zip:__________________ Home Phone Number:__________________

2. I Authorize: __________________ To Release to: __________________

3. ☐ Information to be Mailed ☐ Picked up Date:____________ Location:____________

4. ☐ Information to be faxed: __________________

5. Information to be released: **(1 year history unless specified)**

   ____

   ____

6. X-ray Films: ☐ Yes ☐ No Specify:__________________

> I authorize the release of the indicated sensitive records also (patient to initial):
> Mental Health Records ____(initial)
> HIV or AIDS ____(initial)
> Chemical Dependency ____(initial)

7. Purpose of disclosure:__________________

8. This authorization shall be in effect for 12 months following the date of signature.

9. I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above.

10. I also understand information regarding behavioral or mental health services, treatment for alcohol and drug abuse, and HIV or AIDS cannot be disclosed without this written consent unless otherwise provided in the federal regulations.

11. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

12. I understand that West River Health Services may not condition my treatment or payment of my bills on my decision to sign this authorization.

13. **A photocopy is as valid as the original.**

Signature of Patient or Guardian __________________ Date____________

Relationship to Patient if unable to Sign __________________ Witness____________

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