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

AUTHORIZATION FOR RELEASE OF INFORMATION

ROI Phone: 701-567-6268
ROI Fax: 701-567-6362

Patient	Name:		Date Of Birth:
	Address:		Phone:
	City:	State:	Zip:
	Previous Name:		

Release My Medical Records From

WHO HAS INFORMATION YOU WOULD LIKE RELEASED?

Name: _____ Location: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____

Share My Medical Records With

TO WHOM SHOULD THE INFORMATION BE RELEASED?

Name: _____ Appt Date: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____

Information To Be Disclosed

Medical Record Release:
Records Concerning: _____
Specific Diagnosis Or Treatment And Specific Dates Of Services

- ☐ Past 2 Years Of Records
- ☐ Clinic/Hospital Notes
- ☐ Radiology Reports
- ☐ Radiology Films/Cd/Other
- ☐ Lab/Pathology Reports
- ☐ Immunizations
- ☐ Financial/Billing
- ☐ Last Colonoscopy, Mammogram, Pap, Eye Exam
- ☐ Communication (Check One/Both) ☐ Verbal ☐ Written
- ☐ Other:
- ☐ HIV/AIDS Records
- ☐ Mental Health/Substance Abuse

Reason For The Release

- ☐ Legal
- ☐ Insurance
- ☐ Personal
- ☐ Continuation Of Medical Care
- ☐ Other (Specify): _____
- ☐ Transferring Care (Please Indicate New Provider): _____
- ☐ No records needed at this time; keep on file

Revocation

I understand this authorization will be in effect for 12 months from the date signed unless canceled by me in writing and my cancellation will take effect when the provider receives my notice in writing. A photocopy of this authorization will be treated in the same manner as original.

Authorization

I understand that West River Health Services will not condition my treatment on whether I sign this authorization form, except in the following situations: (1) if treatment is related to research (such as clinical trial), and the information will be disclosed as part of that research; or (2) if the purpose of the treatment is so that information can be disclosed to a third party (such as to an employer for a fitness-for-work examination). I understand that once information is released pursuant to the authorization, West River Health Services cannot prevent the re-disclosure of the information to another third party.

_____ _____
Signature of patient/legal representative* Date

_____
Printed name of legal representative and relationship to patient (Parent, Guardian, Healthcare POA, etc.)

**Authorized representative may be required to submit copies of legal documents supporting his/her authority to act on a patient's behalf*