WEST RIVER
HEALTH SERVICES
1000 HIGHWAY 12 · HETTINGER, ND 58639-7530 · 701-567-4581

# AUTHORIZATION FOR RELEASE OF INFORMATION

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

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|---|---|---|---|
| **Patient** | Name: | | Date Of Birth: |
| | Address: | | Phone: |
| | City: | State: | Zip: |
| | Previous Name: | | |
| **Release My Medical Records From** | **WHO HAS INFORMATION YOU WOULD LIKE RELEASED?**<br>Name: _____ Location: _____<br>Address: _____ Fax #: _____<br>City: _____ State: _____ Zip: _____ | | |
| **Share My Medical Records With** | **TO WHOM SHOULD THE INFORMATION BE RELEASED?**<br>Name: _____ Appt Date: _____<br>Address: _____ Fax #: _____<br>City: _____ State: _____ Zip: _____ | | |
| **Information To Be Disclosed** | Medical Record Release:<br>Records Concerning: _____<br>Specific Diagnosis Or Treatment And Specific Dates Of Services | | |
| | ☐ Past 2 Years Of Records<br>☐ Clinic/Hospital Notes<br>☐ Radiology Reports<br>☐ Radiology Films/Cd/Other<br>☐ Lab/Pathology Reports | ☐ Immunizations<br>☐ Financial/Billing<br>☐ Last Colonoscopy, Mammogram, Pap, Eye Exam<br>☐ Communication (Check One/Both) ☐ Verbal ☐ Written<br>☐ Other: | ☐ HIV/AIDS Records<br>☐ Mental Health/Substance Abuse |
| **Reason For The Release** | ☐ Legal<br>☐ Insurance<br>☐ Personal | ☐ Continuation Of Medical Care<br>☐ Other (Specify): _____<br>☐ 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.<br>_____ _____<br>Signature of patient/legal representative* Date<br>_____<br>Printed name of legal representative and relationship to patient (Parent, Guardian, Healthcare POA, etc.)<br>**Authorized representative may be required to submit copies of legal documents supporting his/her authority to act on a patient's behalf* | | |

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