



1000 Highway 12 - Hettinger, North Dakota 58639 - Telephone 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 released: **(1 year history unless specified)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

5. X-ray Films:  Yes  No Specify: \_\_\_\_\_

6. Purpose of disclosure: \_\_\_\_\_

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

8. 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.

9. 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.

10. 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.

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

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

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient if unable to Sign \_\_\_\_\_ Witness \_\_\_\_\_