Coal Country Community Health Center - Beulah
1312 Highway 49 North; Beulah, ND 58523
PHONE: (701) 873-4445 FAX: (701) 873-4199

Authorization for Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: ___/___/____
Address: _____ Phone #: _____
City/State/Zip: _____ Maiden /Previous Names: _____

Release Information From:

Facility Name: _____
Address: _____
City, State, Zip: _____
Phone: _____

Release Information To:

Facility Name: _____
Address: _____
City, State, Zip: _____
Phone: _____

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL, AND/OR DRUG DEPENENCY, AND OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASE UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING. (I specifically authorize the release of the following:)

□ Psychological _____ □ HIV _____ □ Drug and/or Alcohol Dependency _____

□ **Two-way** ongoing written/verbal for the above information

□ **Check if applicable – Notice to Whomever Disclosure is made concerning addiction records.** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2, a general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

Information to be Released: Service Dates: FROM: _____ **TO:** _____

Note: This authorization expires one year from the date of my signature unless I specify an alternative date: _____

___ Discharge Summary/Clinical Resume	___ Immunization Records	___ Current Medical List
___ History & Physical	___ Laboratory/Radiology Reports(s)	___ Consultation Report
___ Emergency Room Record	___ Advance Directives	___ Allergy Records
___ Entire Medical Record	___ Operative Reports	___ Clinic Visit Notes

___ **Psychiatric & Psychological Evaluations, Assessments, Testing, Notes, Medication, and Diagnosis**

___ **OTHER:** _____

Purpose of Release - This information is requested for the following purpose:

_____ Diagnosis and Treatment	_____ Legal	_____ Personal	_____ Military
_____ Insurance/Billing	_____ Care Coordination	_____ Other: _____	

I may revoke this authorization at any time by sending written notice of this authorization shall not be breach of confidentiality. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand that I may inspect or request copies of any information disclosed under this authorization and I am entitled to a copy of this form if I so requested. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. A photocopy of this authorization is as effective as the original.

_____	_____	_____
(Signature of Participant or Legal Representative)	(Relationship)	(Date)
_____	_____	_____
(Signature of Witness)	(Title)	(Date)