



Coal Country Community Health Center

1312 Highway 49 North; Beulah, ND 58523 701.873.4445
510 8th Ave NE; Hazen ND 58545 701.748.2256 * 111 E Main Street; Center, ND 58530 701.794.8798
220 4th Ave SW; Killdeer, ND 58640 701.764.5822

MEDICAL RECORDS/ROI FAX: (701) 639-4709

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: _____
E-Mail: _____

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:

<input type="checkbox"/> Primary Care Clinic Visit Notes	<input type="checkbox"/> Radiology Report(s)
<input type="checkbox"/> Mental Health Records	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> Substance Use Disorder Records	
<input type="checkbox"/> Laboratory Report(s)	
<input type="checkbox"/> Psychiatric & Psychological Evaluations, Assessments, Testing, Notes, Medication, and Diagnosis	
<input type="checkbox"/> OTHER: _____	

Purpose of Release - This information is requested for the following purpose:			
<input type="checkbox"/> Diagnosis and Treatment	<input type="checkbox"/> Legal	<input type="checkbox"/> Personal	<input type="checkbox"/> Military
<input type="checkbox"/> Insurance/Billing	<input type="checkbox"/> Two-Way Communication	Other: _____	

PATIENT CONSENT: This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice at any time, except to the extent that action has been taken in reliance on it. Refer to the Coal Country Community Health Center’s Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photocopy of this authorization is as effective as the original. Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws. **MINORS SUBSTANCE USE DISORDER TREATMENT INFORMATION:** In accordance with North Dakota State law, the signature of a minor 14 years of age or older is required to disclose Substance Use Disorder Treatment Information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative are required to authorize the disclosure of Substance Use Disorder Treatment Information, including disclosures to the minor's legal representative.

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

Additional Information for Authorization for Disclosure of Protected Health Information

Secure Email Delivery

Protected health and client information will only be sent by **secure email** to outside recipients. If email delivery is requested, a **secure email address** must be provided.

Special Attention: Substance Use Disorder & Psychotherapist Notes

Substance Use Disorder Information

Substance use disorder (drug or alcohol) treatment information is protected by federal law and regulations. If this information is to be disclosed, it must be **specifically described** on the authorization (for example: "all my substance use disorder information").

Psychotherapy Notes

Psychotherapy notes are kept separately by mental health professionals and require a **separate authorization form**. The authorization must identify the **mental health professional** who created the notes.

Client Consent & Signature Requirements

- The individual must **sign and date** the authorization.
- Proper identification may be required at the time of signature.

Legal Representatives

If signed by a legal representative (guardian, agent under power of attorney, etc.):

- The representative must sign and date the form.
- The representative must state their relationship to the individual.
- Documentation verifying legal authority must be on file with the Department or attached.

Minors

- For minors **14 years or older**, the minor must authorize disclosure of sexually transmitted disease, pregnancy related-care, mental health services, or substance use disorder treatment information.
- For minors **13 years or younger**, **both** the minor and the parent/legal guardian must authorize disclosure of sexually transmitted disease or substance use disorder treatment information.