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: ______________________________

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: INITIALS REQUIRED

□ 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
___ History & Physical
___ Emergency Room Record
___ Entire Medical Record
___ Immunization Records
___ Laboratory/Radiology Reports(s)
___ Advance Directives
___ Operative Reports
___ Current Medical List
___ Consultation Report
___ Allergy Records
___ 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 to the Privacy Officer at Coal Country Community Health Center. 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)