



Medcenter One  
medcenterone.com

# Authorization for Disclosure of Medical Information

**FOR INTERNAL USE ONLY**

Please Initial & Date:

Called: \_\_\_\_\_

Faxed: \_\_\_\_\_

Sent: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Maiden/Other Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

I authorize  Verbal  Written release of my medical information.

I authorize release of information from:

- Medcenter One Hospital
- Main Q&R Clinic
- Regional Clinic(s) (Name) \_\_\_\_\_
- Home Health/Hospice
- Nursing Home (Name) \_\_\_\_\_

To be released to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I authorize the mutual exchange of verbal and written information between the parties listed above.

## SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Clinic Records               | <input type="checkbox"/> Hospital Records    | <input type="checkbox"/> Dates of Treatment from _____ to _____ |
| <input type="checkbox"/> Progress Notes/ Clinic Notes | <input type="checkbox"/> Immunizations       | <input type="checkbox"/> EKG Report(s)                          |
| <input type="checkbox"/> Discharge Summary Report(s)  | <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Emergency Dept. Report(s)              |
| <input type="checkbox"/> History & Physical Report(s) | <input type="checkbox"/> Lab Report(s)       | <input type="checkbox"/> Billing Information                    |
| <input type="checkbox"/> Consultation Report(s)       | <input type="checkbox"/> X-Ray Report(s)     | <input type="checkbox"/> Other (Specify) _____                  |
| <input type="checkbox"/> Operative Report(s)          | <input type="checkbox"/> X-Ray Films         | _____   |

## PURPOSE OF THE DISCLOSURE

- Diagnosis and further treatment (Date of appointment \_\_\_\_\_)
- Insurance/ Billing:  Legal  Personal  Military  Other \_\_\_\_\_

**\*\*ALL RECORDS PERTAINING TO PSYCHOTHERAPY/MENTAL HEALTH, CHEMICAL DEPENDENCY, HIV/AIDS RELATED ILLNESS AND TESTING WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.**

- Psychotherapy/ Mental Health (signature) \_\_\_\_\_ (Date) \_\_\_\_\_
- Chemical Dependency (signature) \_\_\_\_\_ (Date) \_\_\_\_\_
- HIV/AIDS related illness/testing (signature) \_\_\_\_\_ (Date) \_\_\_\_\_

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that if I sign this authorization, I have the right to receive a copy of it.

I understand that I may upon written request, inspect or receive a copy of the information to be disclosed.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: \_\_\_\_\_ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

I understand that a processing fee may be charged for me to obtain copies of my medical information.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
(If not patient, state relationship - proof may be required)

\_\_\_\_\_  
Witness



# Instructions for completing the Medcenter One authorization for disclosure of medical information

**Print legibly in all fields and complete all sections. An incomplete form will be returned to you.**

- Patient Name** Print name of patient whose information is to be released.
- Maiden/Other Name** Note any maiden or other names that the patient may have used while at Medcenter One.
- Date of Birth, Phone, SSN** Fill in patient's Date of Birth and a working telephone number. A Social Security Number is helpful, but is not required.
- Verbal/Written Release** Specify whether the form is for verbal or written release. A verbal release is a verbal exchange of information between a health care worker and the listed party. A written release is the release of paper copies of your records.
- Specify which facility the records are coming from, e.g. Medcenter One Hospital, Main Q&R Clinic, Regional Clinics (which include both Walk-In clinics, both Mandan clinics, and both Bismarck Family clinics). If you are requesting records from outside Medcenter One facilities, print the name and address of the hospital or clinic from which the records will be requested on the provided lines.
- Print the name and address of the person or facility receiving the information.
- Mutual Exchange** If the patient authorizes mutual exchange of verbal and written information between parties, check the box.
- Specific Description** Check the appropriate boxes under the Specific Description of Information to be Disclosed section. If the box isn't checked, records of that nature will not be released.
- Dates of Treatment** Enter the dates of treatment from which the records are being released. If the release is intended as ongoing with no expiration date, use "ongoing" as the ending date.
- Purpose of Disclosure** Specify why the information is needed under the Purpose of Disclosure section. If it doesn't fall under one of the categories, specify the reason on the provided line.
- Release of Sensitive Records** Psychotherapy/Mental Health records and those pertaining to Chemical Dependency and HIV/AIDS related illnesses and testing will not be released without a separate signature and date in the box.
- Processing Fee** Read the paragraphs at the bottom of the release. A processing fee may be charged to obtain medical records.
- Expiration of Release** The release will expire one year from the date of signature. If a different expiration date is desired, specify a new date on the provided line.
- The patient must sign and date the form.
- If a Personal Representative, e.g. power of attorney, legal guardian, etc. is signing for the patient, proof may be required showing legal rights to do so.
- A copy of the completed form will be stored in the patient's hospital and clinic record. A copy will be given to the patient upon request.