AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Legal Name: (print) ______________________________ Date of Birth: ______________

Previous Names: ____

Address: ____________________________ City: ________________ State: ______ Zip: _______

Phone: Home _______________ Work _______________ Email: ________________________

1. Please release my records from: (Who has your records?)

☐ Langdon Prairie Health ☐ Hospital ☐ Clinic

☐ Clinic or Organization: ____

Address: ____________________________ City: ________________ State: ______ Zip: _______

Fax: ________________ Phone: ___________________ Email: _________________________

2. Please release my records to: (Who needs your records?)

☐ Langdon Prairie Health, 909 2nd Street, Langdon, ND 58249

☐ Person, Clinic or Organization name: ____

Address: ____________________________ City: ________________ State: ______ Zip: _______

Fax: ________________ Phone: ___________________ Email: _________________________

3. Information to be released: (1 year history unless specified) ________________________________

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This authorization shall remain in effect until the following date: ______/______/______

For condition or dates of treatment: ________________________ Are radiology disks needed? ☐ Yes ☐ No

Date record is needed by: ______________ Will records be picked up? ☐ Yes ☐ No (photo ID required for pick up)

4. Purpose: ☐ Continued care ☐ Personal use – there may be a fee for releasing records ☐ Other ____________

5. Information to be released via the following manner:

☐ Paper ☐ Fax ☐ USB Flash Drive (fees may apply) ☐ Email

6. I understand the following:

- If I change my mind, I may write to the address in section 1 to stop the release of my records. This will not apply to records that have already been released.
- Once the records are released, the clinic or hospital releasing my records cannot prevent them from being released to a third party. At that point, the records may no longer be protected by state and federal privacy laws.
- 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.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.

______________________________ ________________________ ________________

Signature of patient or authorized person Authorized person's authority to sign Date

Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ Guardian