



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)

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.
- Once shared, the records may no longer be protected under the Substance Use Disorder Confidentiality Rule (42 CFR Part 2), but they will still be protected under HIPAA. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.
- 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