

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Information needed by _____
(date)



Patient Name _____ Prior Name: _____

Patient Telephone No. _____

Patient Address: _____
Street City State Zip

Date of Birth _____

INFORMATION TO BE RELEASED:

- | | | |
|---|---|---|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Chemical Dependency Evaluation & Recommendations | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Biopsychosocial History | <input type="checkbox"/> Films |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Psychological | <input type="checkbox"/> Slides |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> CD-PACs |
| <input type="checkbox"/> Operations / Pathology | <input type="checkbox"/> Urine/Serum Drug Screens | <input type="checkbox"/> CD-Med Records |
| <input type="checkbox"/> ETC Report | <input type="checkbox"/> Billing: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Discharge Summary/Planning | | |

Hospital Record # _____

SNF Home Record # _____

Clinic Record # _____

RELEASE FROM:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Trinity Homes | <input type="checkbox"/> ROI / HIM
Trinity Hospitals
P.O. Box 5020
Minot, ND 58702-2020 | <input type="checkbox"/> Trinity Medical Group
(Provider Name) _____

(Provider Address/Phone #) _____ | <input type="checkbox"/> Other Facility

(Provider Address/Phone # - Fax #) _____ |
| <input type="checkbox"/> Trinity Addiction Services | | | |
| <input type="checkbox"/> Trinity Mental Health | | | |
| <input type="checkbox"/> Kenmare Hospital | | | |

RELEASE TO:

** Please mail to ROI / HIM, Trinity Hospitals, PO Box 5020, Minot, ND 58702-5020*

- This information is to be used for: _____ Advertising/Promotion
_____ Referral or Consult _____ Insurance Company
_____ Attorney or Legal Matter _____ Billing

I authorize release of records pertaining to Mental Health, Alcohol and/or Drug Abuse and/or HIV Testing / Aids / Aids related illness.

PATIENT SIGNATURE

Other (Please specify): _____

This release shall only apply to medical and billing records originally generated by the above provider. **Unless approximate dates are identified above, it will be assumed that the release will include specified items for only the most recent two-year period.**

This release of information consent form remains in effect for a maximum of 6 months or until date specified _____ (date)

I understand that I have the **right to revoke this authorization**, except as described on page 8 under "Right To Revoke" of Trinity Health's Notice of Privacy Practices. I may revoke this authorization by writing to the Privacy Officer, P.O. Box 5020, Minot, ND 58702-5020. I understand that information disclosed under **this Authorization could be redisclosed by the recipient and Trinity Health is not responsible. However, the recipient is held to all standards set in all aspects of Federal Regulations 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.** The federal privacy rules may not protect my health information once the recipient rediscloses my health information. **A photocopy or fax of this authorization will be treated in the same manner as the original.**

I understand that **I may decline to sign this authorization.** I understand that Trinity Health may not refuse to treat me if I do not sign this authorization. However, **if the purpose of my treatment is solely to disclose health information to a third party**, the provider may refuse to treat me if I do not agree to authorize disclosure of my health information to that third party.

This release also authorizes verbal communication with law enforcement agencies.

No charge for medical records for continued care. There is a copying fee of \$_____ for medical records released directly to patient(s) for personal use or to others for non-patient care uses. **Make your check payable to the facility releasing the records. Signature, relationship and date needed for request to be processed.**

Prepayment

Signature of Patient or Legal Guardian _____

Relationship _____

Date _____

(NOTE: For Addiction Services, 14 years old or older is considered an adult.)

Initials _____

Department _____



LEG4

Includes Trinity Health, Trinity Hospitals, Trinity Homes, Trinity Community Clinics, Kenmare Community Hospital, KeyCare: Medical, Optical, Pharmacy; B&B Northwest Pharmacy

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