

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

| |
|---|
| Upcoming Appointment Date _____ (date) |
|---|



Patient Name _____ Prior Name: _____

Patient Telephone No. _____

Patient Address: _____
Street City State Zip

Date of Birth _____

INFORMATION TO BE RELEASED:

Hospital & Clinic

Dates of Service: _____ / _____ / _____ through _____ / _____ / _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> EKG | <input type="checkbox"/> Radiology Images |
| <input type="checkbox"/> History and Physical Consultations | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Body Part: _____ |
| <input type="checkbox"/> ER Report | <input type="checkbox"/> Labs | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Operations/Procedures | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Video/Photographs |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medication List | <input type="checkbox"/> Billing: _____ |
| | <input type="checkbox"/> Therapy | <input type="checkbox"/> Other: _____ |

Method of Release

- Paper CD

Method of Delivery

- Fax (Unsecured)*- Only available if less than 50 pages
- Mail
- Pickup
- Email (Secure)
- Email (Unsecure)

*If you choose to receive information via unsecured fax or email, Trinity Health cannot accept responsibility for the security of your records while in transit.

| | | |
|---|---------------|---------------|
| I authorize release of records pertaining to <input type="checkbox"/> Mental Health, <input type="checkbox"/> Alcohol and/or Drug Abuse and/or <input type="checkbox"/> HIV / Aids | | |
| _____ PATIENT SIGNATURE | _____ DATE | _____ TIME |

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

Behavioral Health/Riverside / Psych. (3C)

Dates of Service: _____ / _____ / _____ through _____ / _____ / _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Questionnaires |
| <input type="checkbox"/> History and Physical Consultations | <input type="checkbox"/> Assessments | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Evaluations Testing | |

- Psychotherapy Notes*
*Per 45 CFR 164.524(a)(i), the release of psychotherapy notes is not guaranteed.

Chemical Dependency Unit (CDU)

Dates of Service: _____ / _____ / _____ through _____ / _____ / _____

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Assessments | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History and Physical Consultations | <input type="checkbox"/> Testing | |
| | <input type="checkbox"/> Medication List | |

CAPH (Child & Adolescent Partial Hospitalization)

Dates of Service: _____ / _____ / _____ through _____ / _____ / _____

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Assessments | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History and Physical Consultations | <input type="checkbox"/> Testing | |
| | <input type="checkbox"/> Medication List | |

| |
|----------------------|
| <p>PATIENT LABEL</p> |
|----------------------|

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION



RELEASE FROM:

| | | | | |
|---|--|--|-----------------|-------------|
| <input type="checkbox"/> ROI / HIM Trinity Health P.O. Box 5020 Minot, ND 58702-5020 | <input type="checkbox"/> Trinity Homes | <input type="checkbox"/> Other Facility: | Facility: _____ | Attn: _____ |
| <input type="checkbox"/> Kenmare Hospital | <input type="checkbox"/> Community Ambulance Service | Address: _____ | Phone: _____ | |
| <input type="checkbox"/> TCC-Western Dakota | | City/State/Zip: _____ | Fax: _____ | |

RELEASE Name/Facility: _____ Attn: _____

TO: Address: _____ Suite/Apt #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Fax to (701) 857-5778, Email to Trinity.ROI@trinityhealth.org or Mail to ROI / HIM, Trinity Hospitals, PO Box 5020, Minot, ND 58702-5020

THIS INFORMATION IS TO BE USED FOR:

| | | |
|---|--|--|
| <input type="checkbox"/> Referral or Continued Care | <input type="checkbox"/> Communication | <input type="checkbox"/> Other (Please specify): _____ |
| <input type="checkbox"/> Attorney or Legal Matter | <input type="checkbox"/> Insurance Company | _____ |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Military | |

This release of information consent form remains in effect for a **maximum** of 1 year or until previous date specified ____/____/____.
(form expiration date)

This release shall only apply to medical and billing records. **Unless a specific time period is identified, the release will include specified items for only the most recent two-year period.**

I understand that I have the right to revoke this authorization, except as described on page 9 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.

No charge for medical records released directly to provider / facility for continued care. There is a copying fee for medical records released directly to patient(s) for personal use or to others for non-patient care use. Release of Information Form must be filled out completely for request to be processed. Make your check payable to Trinity Health Release of Information (ROI).

I understand that any release of information from these copies is prohibited. I further understand that the confidentiality of the copies I have obtained cannot be guaranteed by Trinity Health as they are no longer under the control of a Trinity Facility.

Per 45 CFR 164.524(b)(2), please allow up to 30 calendar days for processing

| | | | |
|--|--------------|------|------|
| Signature of Patient or Legal Guardian | Relationship | Date | Time |
|--|--------------|------|------|

| | | | |
|----------------------|------------|------|------|
| Trinity Staff Person | Department | Date | Time |
|----------------------|------------|------|------|

*** Trinity Health does not accept electronic signatures***