AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Upcoming Appointment Date
_____
(date)

TRINITY HEALTH

Patient Name_____Prior Name:_____

Patient Telephone No.

Patient Address:_____
Street City State Zip

Date of Birth

INFORMATION TO BE RELEASED:

Method of Release
☐ **Paper** ☐ **CD** ☐ **Electronic**

Method of Delivery
☐ **Fax (Unsecured)***- Only available if less than 50 pages
☐ **Mail**
☐ **Pickup – St. Joe's 3rd Floor**
☐ **Pickup – Hospital 5th Floor**
☐ **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.
**Radiology Images cannot be sent via e-mail.

Hospital & Clinic
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ Clinic Notes
History and Physical
Consultations
☐ ER Report
☐ Operations/Procedures
☐ Discharge Summary

☐ EKG
Radiology Reports
Labs
Pathology Reports

☐ Medication List
☐ Therapy
☐ Immunizations
☐ HIV/AIDS

☐ Radiology Images
Body Part:_____
☐ Video/Photographs
☐ Billing:_____
☐ Other:_____
_____

Psych. (3C)
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ History and Physical /
Consultations
☐ Discharge Summary

☐ Testing
☐ Medication List
☐ 2-Way Release

☐ Other:_____
_____

Behavioral Health/Riverside
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ Clinic Notes / Assessments /
Evaluations
☐ Testing

☐ Questionnaires
☐ Medication List
☐ 2-Way Release

☐ Other:_____
_____

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

CAPH (Child & Adolescent Partial Hospitalization)
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ Discharge Summary
☐ History and Physical /
Consultations

☐ Assessments
Testing
☐ Evaluations
☐ Medication List

☐ 2-Way Release
☐ Other:_____
_____

I authorize release of records pertaining to Alcohol and/or Drug Abuse

_____ _____ _____
PATIENT SIGNATURE DATE TIME

(NOTE: For Chemical Dependency, 14 years old or older is considered an adult.

Chemical Dependency (CDU)
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ Discharge Summary
☐ History and Physical /
Consultations

☐ Assessments
Testing
☐ Medication List
☐ 2-Way Release

☐ Letters (evaluation,
recommendations,
toxicology, progress,
discharge plan, etc.)

☐ Other:_____
_____

Turn Over →

Includes Trinity Health, Trinity Hospitals, Trinity Homes, Trinity Community Clinics, Kenmare Community Hospital, KeyCare: Medical, Optical

PATIENT LABEL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TRINITY HEALTH

RELEASE FROM:

☐ **ROI / HIM**
Trinity Health
P.O. Box 5020
Minot, ND 58702-5020

☐ **Trinity Homes**

☐ **Community Ambulance Service**

☐ **Kenmare Hospital**

☐ **TCC-Western Dakota**

☐ **Other Facility:**

Facility: _____ **Attn:** _____

Address: _____ **Phone:** _____

City/State/Zip: _____ **Fax:** _____

RELEASE TO:

Name/Facility: _____ **Attn:** _____

Address: _____ **Suite/Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Email: _____

Fax to 701-418-7671, 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:

☐ Referral or Continued Care
☐ Attorney or Legal Matter (to receive a complete legal chart, specify "complete chart" in the Other box on page 1)
☐ Personal
☐ Communication
☐ Insurance Company
☐ Military
☐ Other (Please specify):_____

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.

I understand that I have the right to revoke this authorization. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I may revoke this authorization by writing to Release of Information, 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***

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City: _____ **State:** _____ **Zip:** _____

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