

**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:

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
- ☐ Radiology Images
 - Body Part: _____
 - (Required for release of images)
- ☐ Video/Photographs
- ☐ Other: _____

- ☐ Alcohol/Drug Treatment Records
- ☐ Behavioral Health
- ☐ 2-Way Release

- ☐ Psychotherapy Notes***

Method of Release

- ☐ Paper
- ☐ CD
- ☐ Electronic

Method of Delivery

- ☐ Fax (Unsecured)*- Only available if less than 50 pages
- ☐ Mail
- ☐ Patient Portal
- ☐ Pickup – Hospital 5th Floor
- ☐ Email (Encrypted)
- ☐ Email (Unencrypted)

*If you choose to receive information via unencrypted 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.

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

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.)

- ☐ Itemized Billing

• I understand that all billing information will be sent unless exceptions given.

Exceptions: _____

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)
- ☐ Personal
- ☐ Communication
- ☐ Insurance Company
- ☐ Military

☐ Other (Please specify): _____

Turn Over →

PATIENT LABEL

**AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION**



RELEASE FROM:

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

☐ **Other Facility:**

Facility: _____ **Attn:** _____
Address: _____ **Phone:** _____
City/State/Zip: _____ **Fax:** _____

RELEASE TO: **Name/Facility:** _____ **Attn:** _____
Address: _____ **Suite/Apt #:** _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Fax:** _____
Email: _____

OPTIONS TO SUBMIT COMPLETED FORMS:

- Fax to 701-418-7671
- Email to Trinity.ROI@trinityhealth.org
- Mail to ROI / HIM, Trinity Hospitals, PO Box 5020, Minot, ND 58702-5020

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***