

Print patient's legal name: _____ (Office use only: MR#): _____
Birth Date: _____ Previous names: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (Home) _____ (Work) _____

1. Please release my records from: (Who has your records?)

- Altru Health System or specify: Hosp Clinic Rehab Branch, specify _____
 Clinic or organization _____
Address _____ City: _____
State: _____ Zip Code: _____ Fax: _____ Phone: _____

2. Please release my records to Person, Clinical Care Team or Organization: (Who needs your records?)

- Altru Health System, P.O. Box 6002, Grand Forks, ND 58206-6002
 Person, clinic or organization _____
Address _____ City: _____
State: _____ Zip Code: _____ Fax: _____ Phone: _____

3. Information to be released (1 year history unless specified): _____

I authorize the release of the indicated sensitive records also (patient to initial):
Psychotherapy Notes _____ (initial)
Psychiatry Notes _____ (initial)
HIV or AIDS _____ (initial)
Chemical Dependency _____ (initial)

For condition or dates of treatment: _____
Are Radiology disks needed? Yes No

DATE RECORDS ARE NEEDED BY: _____ Will records be picked up? Yes No (photo ID required for pick up)

4. Purpose: Continued care Personal use EMR-Grant Access Only (There may be a fee for releasing these records.)
 Other _____

5. Information to be released via the following manner:

- Oral Written Flash drive (fees may apply) FAX (continued care only) MyChart Epic EMR

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.
- » 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. I also understand the Chemical Dependency client's/patient's records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. I understand this authorization is voluntary and that I may refuse to sign it. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits.
- » To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- » This form expires one year after I sign it or sooner (specify here: _____)

Date Signature of patient or authorized person Authorized person's authority to sign (proof required)

Reason patient is unable to sign: Minor Deceased Guardian

Office Use Only: CC: X-ray Cardio Pathology Mammo Other, specify: _____

Authorization for
Release of Information



T-7181-0009