Altru Health System | P.O. Box 6002 | Grand Forks, ND 58206-6002
Phone: 800.437.5373, ext. 6145 or 701.780.6145 | Fax: 701.780.1047 or 701.780.5387 | altru.org

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:** *(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):** _____
   _____
   _____
   _____
   For condition or dates of treatment: _____
   Are Radiology disks needed? ☐ Yes ☐ No

   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)

   DATE RECORDS ARE NEEDED BY: _____ Will records be picked up? ☐ Yes ☐ No *(photo ID required for pick up)*
4. **Purpose:** ☐ Continued care ☐ Personal use (**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) ☐ MyHealth
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

Altru HEALTH SYSTEM

T-7181-0009