

## RELEASE OF INFORMATION

### Client Information

Full Name (Last, First, Middle Initial):			Date of Birth:
Previous Name(s):			Phone:
Address:	City:	State:	ZIP:

### Release Information From

Name/Facility:  Cass Co Social Services  COF Employee Health  
 Essentia  Family HealthCare  FCPH  
 Cass Co Jail  Sanford  SEHSC  
 Other: \_\_\_\_\_

Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Phone: \_\_\_\_\_

### Release Information To

Name/Facility:  Cass Co Social Services  COF Employee Health  
 Essentia  Family HealthCare  FCPH  
 Cass Co Jail  Sanford  SEHSC  
 Self  Other: \_\_\_\_\_

Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Phone: \_\_\_\_\_

### Purpose of Release

Continuing Medical Care  Disability Determination  Insurance  Legal  Personal  
 School  Workers' Comp  Other: \_\_\_\_\_

### Delivery Method

Paper via:  Mail **OR**  Pickup **OR**  Fax: \_\_\_\_\_  
 USB Drive via:  Mail **OR**  Pickup  
 Electronic via:  Encrypted email: \_\_\_\_\_  
 Verbal exchange of information

### Information to be Released

**Program** (Required if requesting records from Fargo Cass Public Health):  
 FCPH Clinic  City of Fargo Employee Health  Harm Reduction  Cass County Jail  
 Immunization Program  Home Health  Health Tracks  MCH/NFP  
 Ryan White  Tuberculosis (TB)  Tobacco Cessation  Women's Way

Service Dates Between: \_\_\_\_\_ to \_\_\_\_\_  
 Test/Lab/Pathology Results (May specify: \_\_\_\_\_)  Medication List  Immunization Record  
 History & Physical Assessments/Screenings  Provider/Clinic Visit Notes  Entire Medical Record  
 Other: \_\_\_\_\_

I authorize the disclosure of the following records (initial):  
 \_\_\_\_\_ HIV Testing/Treatment \_\_\_\_\_ Mental Health Services/Treatment \_\_\_\_\_ Alcohol/Drug Treatment

### Persons permitted to receive confidential communication (includes access to medical information and/or medical records)

Name:	Relationship:
Name:	Relationship:

### Client Consent

It is my understanding this release will remain in effect for twelve (12) months from the date of signature. A copy of this document is considered the same as the original. I also understand that signing this form is voluntary and treatment, payment or eligibility for benefits will not be affected if I do not sign this authorization. I understand that if the agency that receives this information is not a healthcare provider covered by HIPAA, the information released to the above may be re-disclosed and is no longer protected by HIPAA regulations. I understand, upon request, I will receive a copy of this form after I have signed it. I understand that I have the right to inspect or copy the health information disclosed. I understand that there may be a charge associated with the release of information services rendered.

I further understand that I may revoke this authorization at any time by notifying the Fargo Cass Public Health in writing, but if I do, it will not have any effect on any actions that were taken before my revocation is received (that is, previously disclosed information would not be a breach of confidentiality). By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that above indicated records to be disclosed will be disclosed in accordance with this authorization.

I declare under the penalty of perjury under the laws of the State of North Dakota that the foregoing is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Client:  Self  Parent  Guardian  Representative  Other: \_\_\_\_\_