

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:	<input type="checkbox"/> Cass Co Social Services	<input type="checkbox"/> COF Employee Health
<input type="checkbox"/> Essentia	<input type="checkbox"/> Family HealthCare	<input type="checkbox"/> FCPH
<input type="checkbox"/> Cass Co Jail	<input type="checkbox"/> Sanford	<input type="checkbox"/> SEHSC
<input type="checkbox"/> Other: _____		
Address:		
City, State, ZIP:		
Phone:		

Release Information To

Name/Facility:	<input type="checkbox"/> Cass Co Social Services	<input type="checkbox"/> COF Employee Health
<input type="checkbox"/> Essentia	<input type="checkbox"/> Family HealthCare	<input type="checkbox"/> FCPH
<input type="checkbox"/> Cass Co Jail	<input type="checkbox"/> Sanford	<input type="checkbox"/> SEHSC
<input type="checkbox"/> Self		
<input type="checkbox"/> Other: _____		
Address:		
City, State, ZIP:		
Phone:		

Purpose of Release

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Personal
<input type="checkbox"/> School	<input type="checkbox"/> Workers' Comp	<input type="checkbox"/> Other: _____		

Delivery Method

Paper via:	<input type="checkbox"/> Mail	OR	<input type="checkbox"/> Pickup	OR	<input type="checkbox"/> Fax: _____
USB Drive via:	<input type="checkbox"/> Mail	OR	<input type="checkbox"/> Pickup		
Electronic via:	<input type="checkbox"/> Encrypted email: _____				
<input type="checkbox"/> Verbal exchange of information					

Information to be Released

Program (Required if requesting records from Fargo Cass Public Health):			
<input type="checkbox"/> FCPH Clinic	<input type="checkbox"/> City of Fargo Employee Health	<input type="checkbox"/> Harm Reduction	<input type="checkbox"/> Cass County Jail
<input type="checkbox"/> Immunization Program	<input type="checkbox"/> Home Health	<input type="checkbox"/> Health Tracks	<input type="checkbox"/> MCH/NFP
<input type="checkbox"/> Ryan White	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Tobacco Cessation	<input type="checkbox"/> Women's Way
Service Dates Between: _____ to _____			
<input type="checkbox"/> Test/Lab/Pathology Results (May specify: _____)	<input type="checkbox"/> Medication List	<input type="checkbox"/> Immunization Record	
<input type="checkbox"/> History & Physical Assessments/Screenings	<input type="checkbox"/> Provider/Clinic Visit Notes	<input type="checkbox"/> Entire Medical Record	
<input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Representative <input type="checkbox"/> Other: _____	