FARGO CASS PUBLIC HEALTH
PUBLIC HEALTH NURSING
1240 25th Street South
Fargo, ND 58103-2367
Phone 701.241.1360 | Fax 701.298.6929
FargoCassPublicHealth.com

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	**Release Information To**
Name/Facility: ☐ Cass Co Social Services ☐ COF Employee Health ☐ Essentia ☐ Family HealthCare ☐ FCPH ☐ Cass Co Jail ☐ Sanford ☐ SEHSC ☐ Other:_____	Name/Facility: ☐ Cass Co Social Services ☐ COF Employee Health ☐ Essentia ☐ Family HealthCare ☐ FCPH ☐ Cass Co Jail ☐ Sanford ☐ SEHSC ☐ Self ☐ Other:_____
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone:	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:_____