Aurora Clinic/North Dakota Center for Dermatology, 1451 44th Ave. S., Ste 121D, Grand Forks, ND 58201
Phone: (701) 732-2700, Fax: (701) 732-2701

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____ _____
Patient Name DOB Phone Number

I authorize: **To: ☐ release to: ☐ obtain information from:**

_____ _____
Name of Individual/Facility Name of Individual/Facility

_____ _____
Address, City, State, Zip Code Address, City, State, Zip Code

_____ _____ _____ _____
Phone # Fax # Phone # Fax #

Information may be communicated in the following manner: _____ Written _____ Fax _____ Verbal

INFORMATION TO BE RELEASED AND/OR OBTAINED

Approximate Date(s) of Service: _____

Date Information Needed/Appointment Date:_____

____ Progress Notes ____ History & Physical ____ Lab/EKG/EEG/Imaging Reports

____Other/Specify:_____

All records pertaining to mental health, alcohol and/or drug abuse/dependence, and/or HIV testing/AIDS/AIDS-related illnesses will be released unless otherwise indicated here:

_____

Records requested for reasons other than continuing care & payment of services will be subject to charges according to the ND Century Code 23-12-14(1)(a) rates : $20.00 for the first 25 pages/$.75 for each additional page.

Purpose of Release:
____Continuing Care ____ Insurance/Payment of Services ____ Legal ____ Disability Determination ___ Other/Specify: _____

I understand that I may revoke this authorization in writing at any time, except where actions have already been taken in reliance on it. I understand that Aurora Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected. Authorization is to be signed by the patient or by the patient's legal guardian if the patient is a minor under 14 years of age for CD treatment, or under 18 years of age for mental health or dual diagnosis services, or is physically or mentally unable to sign for himself/herself. A photocopy of this authorization is considered as valid as the original. If not previously revoked, this authorization automatically expires one year from date signed.

_____ _____
Patient/Legal Guardian Signature Date

_____
Relationship to Patient (if not signed by patient)

_____ _____ _____
Witness Signature Date Time

☐ Check if applicable – **Notice to whomever disclosure is made concerning addiction records**. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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