

Aurora Clinic  
1451 44<sup>th</sup> Ave South, Ste 121D Grand Forks, ND 58201  
Phone: 701-732-2700 Fax: 701-732-2701

## AUTHORIZATION FOR RELEASE OF INFORMATION

\_\_\_\_\_  
Patient Name: First, Middle I, Last

\_\_\_\_\_  
Date of Birth

**I authorize:** \_\_\_\_\_ **To release to: Physician #** \_\_\_\_\_

**Aurora Clinic**

\_\_\_\_\_  
Name of Individual/Facility

\_\_\_\_\_  
Name of Individual/Facility

**1451 44<sup>th</sup> Ave South Ste 121D  
Grand Forks, ND 58201**

\_\_\_\_\_  
Address, City, State, Zip Code

\_\_\_\_\_  
Address, City, State, Zip Code

**(701)732-2700 (701)732-2701**  
Phone# Fax #

( ) ( )  
Phone# Fax #

Indicate Yes/No: Information may be communicated by: \_\_\_\_\_ Written \_\_\_\_\_ Fax \_\_\_\_\_ Verbal

### INFORMATION TO BE RELEASED

Approximate Date(s) of Service: \_\_\_\_\_

Indicate Yes/No: \_\_\_\_\_ Lab Work \_\_\_\_\_ History and Physical

\_\_\_\_\_ Progress Notes \_\_\_\_\_ Other/Specify:

\_\_\_\_\_  
Date Information Needed by Recipient: \_\_\_\_\_

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:

\_\_\_\_\_  
\_\_\_\_\_

Purpose of Release: \_\_\_\_\_ Continuing Care    \_\_\_\_\_ Insurance    \_\_\_\_\_ Legal  
                                 \_\_\_\_\_ Disability Determination    \_\_\_\_\_ Other: Please Specify

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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 NFP 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. Chemical dependency records are protected by Federal Law (42 CFR Part 2) and cannot be disclosed without this written authorization. A photocopy of this authorization is considered as valid as the original.

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if not signed by patient)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date