Healthways
1033 BASIN AVE
BISMARCK ND 58504
PH# 701.223.6613
FAX# 701.221.9114

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ Maiden/Other Name: _____

Date of Birth: _____ Soc Sec No: _____ Phone #: _____

I authorize release of information from: To be released to:

_____ _____

_____ _____

_____ _____

PURPOSE OF THIS REQUEST _____ Date needed by _____

INFORMATION TO BE RELEASED:

_____ Last 2 years medical history and 1 year lab and x-ray reports

_____ Other (please be specific) _____

Records that are of a sensitive nature will not be released unless specifically authorized below.
Any patients 14 years or older must authorize the release of their own sensitive information.

Psychiatric/Mental Health/Chemical Dependency _____ Date_____

Contraception/STDs (if ages 14-17) _____ Date_____

I understand that if records are released to someone who is not a healthcare provider, health plan, or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may be further disclosed without obtaining my authorization.
I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form by contacting the Records Information Nurse.
I understand that if I sign this authorization, I have a right to receive a copy of this form if requested.
I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature.
However, our medical treatment of the patient is not conditional on the signing or failure to sign this form.
This authorization is effective for one year unless otherwise specified as follows: _____. I understand I may cancel this authorization at any time by written notification. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that may have already been released. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the Record Information Nurse.
I understand that Healthways will not receive payment in connection with the use or disclosure of my health information, unless specified here:_____. This does not apply to a reasonable fee for copying and mailing when releasing records directly to the patient. There is no charge if medical records are released to a physician, hospital, clinic, or other medical facility for continued care purposes.

I have had an opportunity to review and understand the contents of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes. I release the staff of Healthways from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

_____ Date _____
Signature of Patient or Legal Representative

_____ _____
If not present, state relationship – proof may be required Witness