CHI St. Alexius Health

Williston Medical Center

1301 15th Avenue West
Williston, ND 58801
Phone: 701.774.7048 • Fax: 701.774.7468

Release of Information

Name of Patient: _____ Date of Birth: _____ Phone: _____

I hereby authorize: _____ _____
(Person or Organization) *(Street)* *(City, State, Zip)*

to use and/or disclose information to: _____
(Person or Organization to receive information)

_____ _____
(Street) *(City, State, Zip)* *(Fax Number)*

from dates: _____ to _____

Expiration: This authorization will expire 60 days from signature and date on authorization form.

INFORMATION TO BE USED AND/OR DISCLOSED:

☐ Emergency Room Records ☐ Laboratory Reports ☐ Pathology Reports ☐ Radiology Reports
☐ Inpatient Records ☐ Outpatient Records ☐ Clinic Notes ☐ Immunization Reports
☐ Operative Reports

☐ Other* *(please specify)*: _____

* If authorization is for ***marketing,*** indicate if CHI St. Alexius Health Williston will receive compensation in exchange for the use and/or disclosure of the PHI. ☐ Yes ☐ No

☐ I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related condition.

PURPOSE OF THE USE AND/OR DISCLOSURE:

☐ Further Treatment ☐ Insurance Application ☐ Legal
☐ Other: _____ ☐ Personal Records

Prohibition on Conditioning of Authorization: CHI St. Alexius Health Williston will not condition treatment on your signing this authorization, unless:

You are receiving research-related treatment or
The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also know as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Revocation: I understand that I may revoke this authorization at any time by notifying CHI St. Alexius Health Williston in writing by sending a letter or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that CHI St. Alexius Health Williston took before it received my revocation letter. For example, CHI St. Alexius Health Williston cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the CHI St. Alexius Health Williston's Notice of Privacy Practices.

_____ _____
Signature of individual or personal representative (relationship) ***Date***

Permanent Copy