Authorization for Use and Disclosure
of Protected Health Information

Patient Name: ______________________________
Patient DOB: ______________________________
Patient MRN: ______________________________

I hereby authorize:
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To Release information to:
Dakota Gastroenterology Clinic
5049 33rd Ave S
Fargo, ND 58104
701-356-1001 Phone
701-639-4550 Fax

Purpose of disclosure:
□ Continuing care
□ Payment of Claim
□ Worker's compensation
□ School
□ Insurance application
□ Personal use
□ Legal
□ Other: ________________________

All information regarding alcohol and/or Drug abuse or behavioral health will be released unless you restrict by initialing below

____ Do not release records from alcohol and/or drug abuse or behavioral health information.

Information to be released: Dates of: ______________________________ to ____________________________

□ Discharge summary	□ H&P □ Consult	□ Labs report	□ X-rays reports and films or CD
□ Pathology reports	□ Procedure reports (Colonoscopy, EGD)		□ Operative reports
□ Immunizations	□ Entire medical records	□ Correspondence	□ Providers Progress notes
□ Other:			

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I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _______________ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

____ ______________________
Signature of Patient/Guardian/Representative Date

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(If not the patient, state authority/relationship)