



Homefield Health
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 Fargo, ND 58102
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Authorization for Release of Medical Information

Name of Patient: _____

Date of Birth: _____ Phone #: _____ Social Security #: _____

I am requesting the below provider release my information to Homefield Health.

I authorize Homefield Health to release my information to the below provider.

Facility: _____ Provider Name: _____

Facility Ph: _____ Facility Fax: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

_____ Any Treatment from _____ (date) to _____ (date)
 _____ Entire Medical Record _____ Mental Health Records _____ Psychological Testing
 _____ Medication List _____ Lab Reports _____ X-Ray Reports
 _____ Discharge Summary _____ Immunizations _____ Operative Report
 _____ Other (please specify) _____

PURPOSE OF THE USE AND DISCLOSURE

_____ Further Treatment (Date of Appointment _____)
 _____ Personal Records _____ Referral to Specialist _____ Disability Determination
 _____ Insurance Application/Claims _____ Workers Comp _____ Other _____

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 the extent action has already been taken in reliance on it. I understand that this authorization will expire 12 months from the signing date.

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

 Signature of Patient/Guardian/Representative

 Date

 PRINT Name of Patient/Guardian/Representative

 (If not patient, state authority/relationship)