BISMARCK
CANCER CENTER

500 North 8th Street, Bismarck ND 58501
Phone: 701-222-6100 Fax: 701-222-6150

Authorization for Disclosure of Medical Information

Print Name: _____ Maiden/Other Name: _____
Address: _____ Birthdate: _____
City, State, Zip: _____ Social Security #: _____
I Authorize _____ To release to: _____
(Name of Facility) (Name)

_____
(Mailing Address)

Information to be released:

_____Clinical records (Consultation, F/U, Treatment Summary, Progress/ Procedure Notes, DDR/Dosimetry Plan, Pathology, Labs, Imaging/Scans)
_____Billing records
_____Other _____

This information is necessary/can be used for the following:

__x_____ Diagnosis and Treatment ____x____Legal ____x____Personal
__x_____Insurance/Billing _____Other _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

1. This authorization will remain effective until the following date, event or condition:_____ If there is no date, event or condition, it will remain effective for 1 year and will automatically expire without my express revocation. I understand that I can revoke this authorization at any time upon written request. Any information released prior to my written revocation of this authorization will not be a breach of confidentiality.
2. I understand that a photocopy or a faxed copy of this release is as valid as the original.
3. 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 under this authorization.
4. I understand that if I sign this authorization, I have a right to receive a copy of it.
5. 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. Medical treatment to the patient is not conditioned on the signing or failure to sign this form.
6. I understand that if the individual or organization that receives this information is not a healthcare provider or health plan covered by the federal privacy regulations, the information released to the above may be redisclosed and is no longer protected by these federal regulations.
7. I understand that I will be contacted if this release is needed for medical diagnosis or treatment for continuation of care.

X _____ _____ _____
(Signature of Patient or Responsible Party) **(Relationship)** **(Date/Time)**

_____ _____ _____
(Signature of Witness) **(Title/Relationship)** **(Date/Time)**

If signed by person other than patient, specify reason patient is unable to sign:

_____ Legal Guardian _____ Parent of Minor
_____ Next of Kin _____ Power of Attorney for Health Care

Date and Time Patient Contacted _____ Signature _____ Witness _____