

Carrington Health Center  
800 North Fourth Street Carrington, ND 58421-0461

## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACCESS TO PROTECTED HEALTH INFORMATION

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize: \_\_\_\_\_  
(Person or Organization)

to use and/or disclose information from dates: \_\_\_\_\_ to \_\_\_\_\_

to: \_\_\_\_\_  
(Person or Organization to receive information) (Street) (City, State, Zip code)

**EXPIRATION:** This authorization will expire \_\_\_\_\_  
(Insert date, event or "once purpose stated above is served")

### INFORMATION TO BE USED AND/OR DISCLOSED:

- Hospital Admission Summary
- Hospital Discharge Summary
- Operative Reports
- Laboratory Reports
- X-Ray Reports
- X-Ray Films
- Other (please specify): \_\_\_\_\_

\* If authorization is for *marketing*, indicate if Carrington Health Center will receive compensation in exchange for the use and/or disclosure of the PHI. \_\_\_\_ Yes or \_\_\_\_ 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 conditions.

### PURPOSE OF THE USE AND/OR DISCLOSURE:

Further Treatment     Insurance Application     Legal     Personal Records     Other \_\_\_\_\_

**Prohibition on Conditioning of Authorization:** Carrington Health Center 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 known 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 Carrington Health Center in writing by sending a letter to the **Privacy Official**, Carrington Health Center, 800 N 4<sup>th</sup> St, Carrington, ND 58421 – 701-652-3141 or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Carrington Health Center took before it received my revocation letter. For example, Carrington Health Center 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 Carrington Health Center’s Notice of Privacy Practices.

\_\_\_\_\_  
**Signature of individual or personal representative (relationship)**

\_\_\_\_\_  
**Date**