AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Information needed by _____ (date)

TRINITY HEALTH

Patient Name_____ Prior Name:_____

Patient Telephone No.

Patient Address:_____
Street City State Zip

Date of Birth

INFORMATION TO BE RELEASED: Dates of Service_____

- ☐ History and Physical
- ☐ Clinic Notes
- ☐ Lab
- ☐ Radiology Reports
- ☐ Operations / Pathology
- ☐ ETC Report
- ☐ Discharge Summary/Planning
- ☐ Chemical Dependency Evaluation & Recommendations
- ☐ Biopsychosocial History
- ☐ Psychological
- ☐ Psychiatric
- ☐ Urine/Serum Drug Screens
- ☐ Billing:_____
- ☐ Pharmacy
- ☐ Films
- ☐ Slides
- ☐ CD–PACs
- ☐ CD–Med Records
- ☐ Other:_____

Method of Release
☐ **Paper** ☐ **Electronic**

Method of Delivery
☐ **Fax** ☐ **Mail**
☐ **Pickup**

RELEASE FROM:

☐ **Trinity Homes**
☐ **Trinity Addiction Services**
☐ **Trinity Mental Health**
☐ **Kenmare Hospital**
☐ **ROI / HIM**
Trinity Hospitals
P.O. Box 5020
Minot, ND 58702-5020
☐ **Trinity Medical Group**
☐ **Other Facility**
_____
_____
_____
_____
_____
(Provider Address/Phone # – Fax #)

RELEASE TO: Legal-Ease Digital Imaging, LLC
P.O. Box 1017
Flint, MI 48501-1017
Ph: 855-534-4003 Fax: 810-547-4030 Email: pat.legalease@gmail.com

**** Please fax to (701) 857-5778 or mail to ROI / HIM, Trinity Hospitals, PO Box 5020, Minot, ND 58702-5020***

This information is to be used for:

_____ Referral or Continued Care _____ Insurance Company
X Attorney or Legal Matter _____ Billing
Other (Please specify):_____

I authorize release of records pertaining to ☐ Mental Health, ☐ Alcohol and/or Drug Abuse and/or ☐ HIV Testing / Aids / Aids related illness.

_____
PATIENT SIGNATURE

(NOTE: For Addiction Services, 14 years old or older is considered an adult.)

This release shall only apply to medical and billing records originally generated by the above provider. **Unless approximate dates are identified above, it will be assumed that the release will include specified items for only the most recent two-year period.**

This release of information consent form remains in effect for a maximum of 6 months or until date specified_____.
(date)

I understand that I have the **right to revoke this authorization**, except as described on page 8 under "Right To Revoke" of Trinity Health's Notice of Privacy Practices. I may revoke this authorization by writing to the Privacy Officer, P.O. Box 5020, Minot, ND 58702-5020. I understand that information disclosed under **this Authorization could be redisclosed by the recipient and Trinity Health is not responsible. However, the recipient is held to all standards set in all aspects of Federal Regulations 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.** The federal privacy rules may not protect my health information once the recipient rediscloses my health information. **A photocopy or fax of this authorization will be treated in the same manner as the original.**

I understand that **I may decline to sign this authorization**. I understand that Trinity Health may not refuse to treat me if I do not sign this authorization. However, **if the purpose of my treatment is solely to disclose health information to a third party**, the provider may refuse to treat me if I do not agree to authorize disclosure of my health information to that third party.

This release also authorizes verbal communication with law enforcement agencies.

No charge for medical records released directly to provider / facility for continued care. There is a copying fee for medical records released directly to patient(s) for personal use or to others for non-patient care use. Release of Information Form must be filled out completely for request to be processed. **Make your check payable to the facility releasing the records.**

_____ Signature of Patient or Legal Guardian

_____ Relationship

_____ Date

_____ Initials

_____ Department

LEG4

Includes Trinity Health, Trinity Hospitals, Trinity Homes, Trinity Community Clinics, Kenmare Community Hospital, KeyCare: Medical, Optical, Pharmacy; B&B Northwest Pharmacy

RECEIPT OF MEDICAL RECORDS

TRINITY HEALTH

I_____ have received the copies of a medical record

for_____ with dates of service from

_____ to _____.

I understand that any release of information from these copies is prohibited. I further understand that the confidentiality of the copies I have obtained cannot be guaranteed by Trinity Health as they are no longer under the control of a Trinity Facility.

_____ _____
Patient/Representative Date

_____ _____
Trinity Staff Person Dept. Date

Completed:

_____ _____ _____
Method Date Tracking #