AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Upcoming Appointment Date
_____
(date)

TRINITY HEALTH

Patient Name_____Prior Name:_____

Patient Address:_____
Street City State Zip

_____
Patient Telephone No.

_____
Date of Birth

INFORMATION TO BE RELEASED:

Method of Release
☐ **Paper** ☐ **CD**

Method of Delivery
☐ **Fax (Unsecured)***
☐ **Mail**
☐ **Pickup**
☐ **Email**

*If you choose to receive information via unsecured fax, Trinity Health cannot accept responsibility for the security of your records while in transit.

Hospital & Clinic
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ Clinic Notes
History and Physical
Consultations
☐ ER Report
☐ Operations/Procedures
☐ Discharge Summary

☐ EKG
Radiology Reports
Labs
Pathology Reports
☐ Medication List
☐ Therapy

☐ Radiology Images
Body Part:_____
☐ Immunizations
☐ Video/Photographs
☐ Billing:_____
☐ Other:_____
_____

I authorize release of records pertaining to ☐ ***Mental Health,***
☐ ***Alcohol and/or Drug Abuse and/or*** ☐ ***HIV / Aids***

_____ _____ _____
PATIENT SIGNATURE DATE TIME

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

Behavioral Health/Riverside / Psych. (3C)
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ Clinic Notes
History and Physical
Consultations
☐ Medication List

☐ Discharge Summary
☐ Assessments
Evaluations
Testing

☐ Other:_____
_____

Chemical Dependency Unit (CDU)
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ Discharge Summary
☐ History and Physical
Consultations

☐ Assessments
Testing
☐ Medication List

☐ Other:_____
_____

CAPH (Child & Adolescent Partial Hospitalization)
Dates of Service:_____ /_____ /_____ through _____ /_____ /_____

☐ Discharge Summary
☐ History and Physical
Consultations

☐ Assessments
Testing
☐ Medication List

☐ Other:_____
_____

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

☐ ***Request Complete***

PATIENT LABEL

LEG4

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TRINITY HEALTH

RELEASE FROM:

☐ **ROI / HIM**
Trinity Health
P.O. Box 5020
Minot, ND 58702-5020

☐ **Trinity Homes** ☐ **Kenmare Hospital** ☐ **Community Ambulance Service**

☐ **Other Facility:** **Facility:** _____ **Attn:** _____

Address: _____ **Phone:** _____

City/State/Zip: _____ **Fax:** _____

RELEASE TO:

Name/Facility: Legal-Ease Digital Imaging **Attn:** Pat

Address: P.O. Box 1017 **Suite/Apt #:** _____

City: Flint **State:** MI **Zip:** 48501-1017

Phone: 855-534-4003 **Fax:** 810-547-4030

Email: pat.legalease@gmail.com

Fax to (701) 857-5778, Email to Trinity.ROI@trinityhealth.org 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
☐ Attorney or Legal Matter
☐ Personal
☐ Communication
☐ Insurance Company
☐ Military
☐ Other (Please specify):_____

This release of information consent form remains in effect for a **maximum** of 1 year or until previous date specified_____/_____/_____.
(form expiration date)

This release shall only apply to medical and billing records. **Unless a specific time period is identified, the release will include specified items for only the most recent two-year period.**

I understand that I have the right to revoke this authorization, except as described on page 9 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.

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 Trinity Health Release of Information (ROI).

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.

Please allow 5-7 business days for processing

Signature of Patient or Legal Guardian	Relationship	Date	Time

Trinity Staff Person	Department	Date	Time

*** Trinity Health does not accept electronic signatures***