Good Samaritan Hospital Association
Heart of America Medical Center

800 S Main Ave ● Rugby ND 58368 ● Ph: 701-776-5261 ● Fax: 701-776-5448

RELEASE OF INFORMATION

RUGBY CLINIC
Main Clinic Office
1.800.235.0075
Ph: 701.776.5235
Fax: 701.776.5297

MADDOCK CLINIC
301 Roosevelt Ave
Maddock, ND 58348
Ph: 701.438.2555
Fax: 701.438.2551

DUNSEITH CLINIC
215 Main St. SE
PO Box 88
Dunseith, ND 58329
Ph: 701.244.5694
Fax: 701.244.5329

TOWNER CLINIC
2 3RD Ave SW
P. O. Box 583
Towner, ND 58788
Ph: 701.537.0537
Fax: 701.537.5779

Patient Name__________________________ **Phone Number**________________

Date of Birth____/____/____ **Social Security Number**____________________

I authorize ____
(Physician, facility, etc)

____
Address Phone Fax

To release my patient information to ____________________________________
(Facility/Provider)

____
Address Phone Fax

Reason:
□Continuation of Care □Legal □Personal □Insurance □Other______________

Date of Treatment: from______________________ to______________________

Information to be disclosed:

__Discharge Summary	__Operative Report	__Labs
__History and Physical	__Progress Notes	__EKG/Cardiac
__Consultation	__Physician Orders	__Prescription
__Radiology report	__ER Report	__Clinic Notes
__Radiology films	__Business record	__Other (specify) ___________

I authorize the release of records containing the following information:

□ Mental Health __________________ Initial_______ Date________
□ Substance Abuse ________________ Initial_______ Date _______
□ HIV ___________________________ Initial_______ Date________
□ Other__________________________ Initial_______ Date________

Copy Fee:
We reserve the right to charge a reasonable fee for the cost of producing and mailing or faxing the copies. The first 25 pages will be $20 with $0.75 for each additional page.

Email
Electronic releases are **not** recommended, but can be done with the understanding that there is no 100% secure electronic release of information. Please consider using our patient portal, MyHealth, for your electronic records. If you still choose to have your records released via email we will only email them to your personal email address.
Personal Email Address: ____

Revocation:
I understand that this authorization will remain in effect for 90 days from the date of signature, unless otherwise stated. I also understand that I may revoke this authorization by submitting a written revocation to GSHA; however, this would not apply to any information already disclosed in good faith. To submit a revocation, please contact the HIPAA Privacy Officer. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

______________________________________ _____/_____/______
Signature Date

______________________________________ ___________________
Printed Name Relationship to Patient

For Facility Use
Completed ❐
Initials_______
Date_________
Pages______
8/2016