BRIGHTSIDE
SPECIALTY CLINICS
310 N 10th St | Bismarck ND 58501

Authorization For Release of Patient Information

Patient Name ________________________ Maiden/Other Name ________________________

Date of Birth ________________ Soc. Sec. No. ________________ Phone ________________

I authorize release of information from: ________________________

To be released to: ________________________

PURPOSE OF THIS REQUEST (required) ________________________ Date needed by ________________

INFORMATION TO BE RELEASED:

- ☐ last 2 years medical history & 1 year lab & x-ray reports
- ☐ other (please be specific) ________________________

Records that are of a sensitive nature will not be released unless specifically authorized below.
Any patients 14 years or older must authorize the release of their own sensitive information.

Psychiatric/Mental Health/Chemical Dependency ________________ Date ________________

Contraception/STDs (if ages 14-17) ________________ Date ________________

I understand that if records are released to someone who is not a healthcare provider, health plan, or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may be further disclosed without obtaining my authorization.

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 by this authorization form by contacting the Release of Records Department.

I understand that if I sign this authorization, I have a right to receive a copy of this form if requested.

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. However, our medical treatment of the patient is not conditional on the signing or failure to sign this form.

This authorization is effective for one year unless otherwise specified as follows: ________________________

I understand I may cancel this authorization at any time by written notification. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that may have already been released. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the Release of Records Department.

I understand that Brightside Specialty Clinics will not receive payment in connection with the use or disclosure of my health information, unless specified here ________________________.
This does not apply to a reasonable fee for copying and mailing when releasing records directly to the patient. There is no charge if medical records are released to a physician, hospital, clinic, or other medical facility for continued care purposes. See the back of this form for details.

I have had an opportunity to review and understand the contents of this authorization. By signing this authorization I am confirming that it accurately reflects my wishes. I release the staff of Brightside Specialty Clinics from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

________________________ ________________
Signature of Patient or Legal Representative Date

________________________ ________________
If not present, state relationship – proof may be required Witness

PLEASE READ INFORMATION ON BACK

If this request is for the purpose of continuing medical care, we will attempt to process the request within 72 hours. Allow up to 30 days for all other requests, including legal, personal, and applications for life, health, and disability insurance.

The charges for the release of medical records:

1. There is no charge if medical records are released directly to a physician, hospital, clinic, or other medical facility for continued care purposes.
2. There is no charge if a medical facility specifically requests that you hand carry your medical records and your Brightside Specialty Clinics physician knows you are going to another medical facility.
3. There may be a nominal fee charged to the patient when records are released directly to them.