Medical Records

Your medical records are an important part of your continuing health care. You have the right to request copies, either for your own use in managing your health information or for your physicians use when transferring care to another facility.

1. How to request your medical records:
2. Download and print authorization form.
3. Fill out the form as completely as you can.
   a. Include both the name and address that you would like your records released to or obtained from
   b. Be as specific as you can about the information that you’d like released or obtained (e.g. specific dates of service, specific treatment, just immunizations, etc.)
4. Please mail or fax your authorization to the address below. Forms can also be dropped off at any
5. Family HealthCare location. We do not accept email or online submissions.

There may be a charge for copies of your medical records. If there is a, we will be notify you before copies are made. For more information please contact the Health Information department at the number below.

Family Healthcare
Health Information
301 NP Avenue
Fargo, ND 58102

Phone: (701) 271-3344
Fax: (701) 271-3347
STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>(Maiden or other Names Used)</th>
</tr>
</thead>
</table>

Patient Address

Phone Number

AUTHORIZES FAMILY HEALTHCARE TO
RELEASE TO:

<table>
<thead>
<tr>
<th>Name of Health Care Provider/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
</tr>
</tbody>
</table>

AUTHORIZES FAMILY HEALTHCARE TO
OBTAIN FROM:

<table>
<thead>
<tr>
<th>Name of Health Care Provider/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
</tr>
</tbody>
</table>

Place ✓ in the appropriate boxes

Information to be disclosed:

- General Release (last 2 years)
- Obstetrical Records
- Immunization Records
- Lab Reports (Specify)
- Dental
- Consultation Reports
- Specific Release time period
- X-ray/Imaging Reports
- Drug/Alcohol Treatment
- Mental Health
- Other (Specify)

From ________ To ________

I authorize the release of all mental health and drug and/or alcohol treatment records that are part of the records specified above unless indicated here:

- Do not release drug or alcohol treatment records protected under federal law (42CFR, Section 2)
- Do not release mental health records protected under federal law (42CFR, Section 2)

Initials

Records needed for:

- Personal
- Legal
- Insurance
- Healthcare, Appt on:
- Other (specify)

Note: We will not re-disclose records obtained from other facilities.

Expiration Date of Authorization: This authorization is effective through ____/____/____ unless revoked or terminated by my personal representative or me. If no date is indicated, authorization will remain in effect for one year from the signature date, and will automatically expire without my revocation.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Family HealthCare Center.

Potential for Re-disclosure: Information being disclosed to other health care providers for continuum of care may include information received from other healthcare entities with the exception of Mental Health or Chemical Dependency notes. The privacy of this information may not be protected under the federal privacy regulations.

I understand that any release that was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining an individual’s authorization. I direct that a photocopy or FAX copy of this authorization be granted the same authority as the original.

__________________________
Signature of Patient/Parent/Guardian

(* If patient is a minor, parent/guardian MUST sign unless patient emancipated)

__________________________
Date

(* Adults MUST sign for themselves unless incapacitated)

__________________________
Witness

Charges:

| No charge/1-10 pages |
| $15/11-24 pages     |
| $20/25 pages        |
| $0.75/each add’l page |

Faxed by: Date:

Legal authority if signed by person other than patient (proof required):

□ Parent of Minor
□ Legal Guardian
□ Next of Kin
□ Power of Attorney of Healthcare

□ ID Shown:

FHC – 107 / R050714