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

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name ______________________________ ______________________
Last First Middle (Maiden or other Names Used)

Patient Address ______________________________ Date of Birth ______________
______________________________ Social Security No. ______________
Phone Number ______________________________ **FHC #** ______________

AUTHORIZES FAMILY HEALTHCARE TO <u>RELEASE TO:</u>

____
Name of Health Care Provider/Other
____
Street Address
____
City, State, Zip Code

AUTHORIZES FAMILY HEALTHCARE TO <u>OBTAIN FROM:</u>

____
Name of Health Care Provider/Other
____
Street Address
____
City, State, Zip Code

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 From ________ To ________
- ☐ X-ray/Imaging Reports
- ☐ Drug/Alcohol Treatment
- ☐ Mental Health
- ☐ Other (Specify) ______________

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)
Initials

________ 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 provides 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 Date Witness
(* If patient is a minor, parent/guardian **MUST** sign unless patient emancipated) (* Adults **MUST** sign for themselves unless incapacitated)

CLINIC EMPLOYEES ONLY	**Charges**: **No charge**/1-10 pages **$15**/11-24 pages **$20**/25 pages **$0.75**/each add'l page Faxed by: Date: ________

☐ Parent of Minor ☐ Legal Guardian ☐ Next of Kin ☐ Power of Attorney of Healthcare
☐ ID Shown: ____________

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