AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ CHART#: _____

BIRTH DATE: _____ PHONE: _____

I HEREBY AUTHORIZE: _____

TO RELEASE MY RECORDS TO: OrthoDakota, LLC
2829 University Dr. S, Ste 202
Fargo, ND 58103
P: 701-707-0200 F: 701-707-0210

SPECIFIC DESCRIPTION OF INFORMATION TO BE RELEASED

TREATMENT DATES FROM:_____ TO _____
___ CLINIC NOTES ___OPERATIVE REPORTS ___DISCHARGE SUMMARIES ___HISTORY & PHYSICAL
___ IMAGING REPORTS ___IMAGING STUDIES(XRAY/MRI/CT/US) ___CORRESPONDENCE
___ BILLING INFORMATION ___ OTHER_____

THE DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):
___ FURTHER TREATMENT – DATE OF APPOINTMENT: _____.
___ INSURANCE/BILLING ___ LEGAL
___ PERSONAL ___ OTHER _____

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on information released prior to notification of revocation. This authorization will remain in effect until:_____ (date). If no date is indicated, authorization will remain in effect for one year from the signature date and will automatically expire without my revocation. A photocopy/fax of this authorization will be treated in the same manner as the original. OrthoDakota, LLC will not refuse or restrict my treatment if I choose not to sign this authorization.

Further, I realize that OrthoDakota, LLC cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections. Therefore, OrthoDakota, LLC is released from any and all liability resulting from redisclosure.

_____ _____
Signature of Patient or Representative Date

_____
(If not patient, state authority/relationship)