The Bone & Joint Center
310 N 9th Street, PO Box 1397
Bismarck, ND 58502
Phone: 701-530-8687 Fax: 701-530-8730

Medical Records Release Form (FORM E1)

Patient Name: _____

Date of Birth: _____

Phone Number/s: _____

Patient's Complete Mailing Address:

_____

_____

I, _____, hereby authorize the Bone & Joint Center to use or disclose the
(Name)

following protected health information to: _____
(Name and address of individual or organization to receive information)

By: ☐ Fax _____ ☐ Mail _____
(Please provide fax number) (Name)

_____
(Address)

☐ Hand Carry

_____
(City) (State) (Zip Code)

Release information from my medical records **for dates of service from _____ to _____.**

____Doctor/Clinic Notes
____Consultation Report
____Operative Report
____Billing Records
____Radiology(x-ray/MRI) reports
____Pathology Report
____X-ray Films (Body Part)_____ ☐ Left ☐ Right
____Physical Therapy/Occupational Therapy
____Clinical Resume/Discharge Summary
____History and Physical Report
____Laboratory Report
____Other (Please Specify)_____

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV-RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records:

☐ Drug And/Or Alcohol Dependency _____ (Initials)
☐ Psychiatric/Psychological _____ (Initials)
☐ HIV _____ (Initials)

The information is necessary for the following **purpose**:

☐ Diagnosis and Treatment ☐ Legal ☐ Military ☐ Personal **(Charge after the first 5 pages)**
☐ Insurance/Billing _____ ☐ Other:_____
(Name of Insurance Company)

___

This authorization shall be in force and effect until: ☐ Date _____ OR one year.

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1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority