The Bone & Joint Center

The Bone & Joint Center, P.C.
310 N 9th St Bismarck, ND 58501
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701-946-7406 Fax: 701-354-2507

Release of Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

_____ MRN: _____

Maiden/Previous Names: _____

Release Information From:

Facility Name: _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Fax: _____

Release Information To:

Facility Name/Person: _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Fax: _____

INFORMATION TO BE RELEASED: Service Dates: FROM: _____ TO: _____

- ☐ Doctor/Clinic Notes
- ☐ History and Physical Report
- ☐ Laboratory Report
- ☐ Billing Records
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Pathology Report
- ☐ X-ray Films (Body Part)
- ☐ Clinical Resume/Discharge Summary
- ☐ Physical Therapy/Occupational Therapy
- ☐ Radiology (x-ray/MRI) Reports
- ☐ Left ☐ Right
- ☐ 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)

Purpose of Release – This information is requested for the following purpose:

- ☐ Diagnosis and Treatment
- ☐ Legal
- ☐ Personal
- ☐ Military
- ☐ Insurance/Billing
- ☐ Care Coordination
- ☐ Other _____

NOTE: This authorization expires one year from the date of my signature unless I specify an alternative date: _____

I understand there may be a prepayment for records. 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. 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. 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. 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. A photocopy of this authorization is as effective as the original.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Description of Personal Representative's Authority