SAINT SOPHIE'S PSYCHIATRIC CENTER	Patient Name:	U
Authorization for Release of Information - Clinic	Date of Birth:	

I authorize Saint Sophie's, Mailing Address 3201 33rd St S Fargo, ND 58104 fax 701-365-0727 phone 701-365-4488
To Release to: ___ yes ___ no
To Obtain from: ___ yes ___ no

X_____
(Name and Organization)

X_____ X_____ _____ _____
(Street Address) (City, State, Zip Code) (Telephone) (Fax #)

Information may be communicated: (Indicate Y/N) ____ _____ Written _____ Faxed _____ Verbal

INFORMATION TO BE RELEASED

Y Psychological Testing
Y Psychiatric Evaluation
Y Acknowledgement of Patient's Access of Service
Y Progress Notes
Y Treatment Plans
Y Discharge/Final Diagnosis
Y Progress in Treatment

This information is necessary for: (check all that apply)

☒ Assessment, Treatment ☒ Coordination and Follow up ☒ Acknowledge Referral
❑ Education Purposes ❑ Psychological Evaluation/testing
❑ Insurance Purposes ❑ Legal Purposes
❑ Other (must specify) _____

This Consent to Release Confidential Information remains in effect for one year from date signed for this information and date of service only. If you would like to authorize disclosure of your protected health information on a continuing basis that was approved to be released on this form to the person, agency, or organization listed, you must sign below.

This authorization for continuation to release your information will be valid for a year unless otherwise specified. Date Specified: _____

I understand that I may revoke this authorization at anytime except to the extent that action has been taken in reliance on it. Refer to the Privacy Notice for instructions regarding how to revoke authorizations or to inspect or receive copies of this information.

I understand that authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization. I further acknowledge that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by Federal confidentiality rules. Chemical Dependency records are further protected by a more stringent Federal Law (42 CFR Part 2). This information cannot be disclosed without the expressed authorization of the patient nor can the information be re-disclosed unless specifically authorized by the patient or as otherwise permitted by 42 CFR Part 2. I do not authorize further release to any third party and hereby release the hospital, clinic, and their employees and my physician(s) for any and all liability arising directly or indirectly from such a re-disclosure. A copy or fax of this authorization shall be as valid and may be used and relied upon with the same force and effect as the signed original thereof.

Any and all medical records including records relating to communicable disease such as HIV, AIDS, and sexually transmitted diseases will be released unless otherwise indicated by placing patient/legal representative's initials here: ____.
Any and all medical records including records relating to mental health records or chemical dependency records will be released unless otherwise indicated by placing patient/legal representative's initials here ____.

X_____Date_____ X_____ Date_____
Signature of Patient Signature of Witness

X_____Date_____X_____
Signature of Parent/Guardian **Expiration Date of Release-Must Remain Under One Year**