



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Select: MEDICAL RECORDS DENTAL RECORDS BEHAVIORAL HEALTH

Last Name: First Name:

Date of Birth: Primary Phone:

Relationship: Self Parent/Guardian DSS Power of Attorney Other:

Mark if you want MedNorth to RELEASE records to the name listed below:

Mark if you want MedNorth to RECEIVE records from another Provider/Person listed below:

Where records are GOING TO OR COMING FROM:

Name:

Address:

Phone: Fax:

Information to be Released

(please mark the box)

- Provider Notes Lab Radiology Face sheet/Demographics
- Immunization record Dental progress notes Dental X-rays Other:
- Medical Record set (demographics, office notes, test results, lab)

Dates of Service Requested

Special Disclosure

(requires special consent by law)

Expiration Date Purpose

Your Rights

From: To: All available dates

I specifically authorize release of the following information:

(Initial each item you authorize to release/receive)

(Initial here) <input type="text"/>	CCA/Psychosocial Assessment (Initial here) <input type="text"/>	Treatment Plan
(Initial here) <input type="text"/>	Psychological Evaluation (Initial here) <input type="text"/>	Medication List
(Initial here) <input type="text"/>	Psychiatry notes (Initial here) <input type="text"/>	Other: <input type="text"/>

The authorization lasts for **one year** after the date you sign it unless you enter a different date here:

(leave blank = 1-year default)

- Coordination of care Legal Disability/Insurance Other:
- Personal Use Fees may be charged in accordance with Federal Rule 45 CFR 164.524

- The Authorization form is voluntary, and you may refuse to sign it. You may also cross out any words on this form that you do not agree with.
- MedNorth will not restrict your treatment if you choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as the original.
- MedNorth records may include records that it received from other organizations. If these records have been used by MedNorth and filed in the record MedNorth maintains about you, these records may be released with your MedNorth records.
- MedNorth cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release MedNorth from any and all liability resulting from a redisclosure of the recipient.
- Records covered under Federal Rule 42 CFR part 2 and the HIPAA Act of 1996, 45 CFR 160 & 164 and state confidentiality law governing substance abuse services (GS 112C) cannot be disclosed or redisclosed without your written consent unless otherwise provided for in the regulations. You can revoke your authorization by completing section below at any time.
- Substance abuse information may be shared without consent to the extent necessary to meet a bona fide medical emergency.
- Redisclosure of substance abuse information without consent is restricted to any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- Medical information related to reproductive health is prohibited from release to conduct a criminal, civil or administrative liability for seeking, or obtaining reproductive healthcare where such healthcare is lawful under the circumstances it is provided. I attest that the information requested is not related to criminal, civil, or administrative liability for this patient for the act of seeking, obtaining, providing, or facilitating reproductive health where such health care is lawful under the circumstances it was provided.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE

Signature of Patient/Parent/Guardian/POA Printed Name Date

Request type: For chart only Request records URGENT

Completed on — Staff Use Only — Incomplete/unable to process ROI 2026-2

--- Any incomplete forms will be considered invalid and will not be accepted or processed in order to maintain full compliance with HIPAA regulations (45 CFR 164.508).



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Note: If the patient is a minor, lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient:

Healthcare Agent/POA Parent/Guardian Executor/Administrator Social services

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization.

Signature of Minor	Printed Name	Date
<hr/>	<input type="text"/>	<input type="text"/>

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of

(Name of Client) signed by (Enter Name of Person Who Signed Authorization)

on (Enter Date of Signature) be rescinded, effective

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Patient Date

Signature of Witness Date