Great Plains
Women's Health Center P.C.

Phone (701) 774-7687
Fax (701) 572-1695
1700 11th Street W
Williston, ND 58801

Release of Information

Today's Date_____

Patient Name _____ DOB_____

Address_____

City, State, Zip_____ Phone Number_____

I authorize Great Plains Women's Health Center, P.C. to use and/or disclose my individually identifiable health information as described below.

RELEASE MY MEDICAL RECORDS TO:

Physician, Facility or Self _____

Address _____

City, State and Zip Code _____

Telephone Number _____

Fax Number _____

OBTAIN MY MEDICAL RECORD FROM:

Physician or Facility _____

Address _____

City, State and Zip Code _____

Telephone Number _____

Fax Number _____

Records to be released: ALL or Specify _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV, AIDS virus, or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give authorization for these records to be released:

HIV/AIDS	_____ (initial)
Sexually Transmitted Diseases	_____ (initial)
Mental Illness or Mental Health Treatment	_____ (initial)
Drug and/or Alcohol Abuse Treatment	_____ (initial)

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Reason for Release

_____ Specialist Appointment (Please Specify Date) _____

_____ Leaving Practice (Please Specify Reason) _____

_____ Attorney/Legal

_____ Insurance Company or Disability Claim

_____ Other (Please Specify Reason) _____

_____ Request to access, inspect, or obtain a copy of my medical record (Please Specify) _____

Re-disclosure:
I understand that the information used and/or disclosed according this this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

Expiration:
This authorization will expire in 60 days.

Revocation:
I understand that I may revoke this authorization at any time by notifying Great Plains Women's Health Center in writing by sending a letter to 1700 1th St. W, Williston, ND 58801. I understand that if I revoke this authorization, it will not affect any actions that Great Plans Women's Health Center took before it received my revocation letter. For example, Great Plains Women's Health Center cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This authorization is binding:
The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Great Plains Women's Health Center Notice of Privacy Practices.

Signature of Patient or Patient Representative _____

Printed Name of Patient or Patient Representative _____

Date _____