RURAL PSYCHIATRY ASSOCIATES
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ DOB _____ Phone Number _____

I authorize:

Rural Psychiatry Associates
PO Box 5210
Grand Forks, ND 58206
Phone: (701) 205-3000
Fax: (701) 732-2501

To ☐ release to: ☐ obtain information from:

Name of Individual/Facility _____

Address _____

City, State, Zip Code _____

Phone# _____

Fax# _____

How information may be communicated: □ Written □ Fax □ Verbal

INFORMATION TO BE RELEASED AND/OR OBTAINED

Approximate Date(s) of Service: _____

Indicate Y/N:
- ☐ Psychiatric Evaluation
- ☐ Psychological/Neuropsychological Evaluation
- ☐ Progress Notes
- ☐ Lab/EKG/EEG/Imaging Reports
- ☐ H&P
- ☐ Consults
- ☐ Other/Specify: _____

Date Information Needed: _____

All records pertaining to mental health, alcohol and/or drug abuse/dependence, and/or HIV testing, AIDS/AIDS-related illnesses will be released unless otherwise indicated here:

_____

Purpose of Release:
Requests other than for continuing care may be subject to charges according to the ND Century Code 23-12-14(1)(a) rates: $20.00 for the first 25 pages/$.75 for each additional page.

- ☐ Continuing Care
- ☐ School
- ☐ Insurance
- ☐ Legal
- ☐ Disability Determination
- ☐ Other/Specify: _____

I understand that I may revoke this authorization in writing at any time, except where actions have already been taken in reliance on it. I understand that PMC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected. Chemical dependency records are protected by Federal Law (42 CFR Part 2) and cannot be disclosed without this written authorization. A photocopy of this authorization is considered as valid as the original. If not previously revoked, this authorization automatically expires one year from date signed.

Patient/Legal Guardian Signature _____ Date _____

Relationship to Patient (if not signed by patient) _____

Witness Signature (Optional) _____ Date _____

*By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Distribution:
□ Patient/guardian received copy
□ Patient/guardian declined copy