PRAIRIE ST. JOHN'S™

Name of Patient

DOB Phone Number

Maiden/Other Names

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RM.204.F03a

Authorization for Exchange of Protected Health Information

I authorize Prairie St. John's, 510 4th Street South, Fargo, ND 58103 to Exchange confidential information with:

(Name and Organization) (Telephone) (Fax #)

(Street Address) (City, State, Zip Code)

Information will be faxed or mailed if no fax number is provided. We are unable to email protected health information.

Treatment from:

____Most Recent Admission *OR* _____ (Date) to _____ (Date) *OR* ___ Entire Medical Record History

AND ____Future Treatment *(if no specific treatment dates are marked, records will be sent from most recent stay)*

INFORMATION TO BE EXCHANGED:

Indicate Y/N	Document Exchange	Date Sent	Sent by Initials		Indicate Y/N	Document Exchange	Date Sent	Initials
	Psychiatric Assessment					Lab Results		
	Discharge Summary					Substance Use Evaluation		
	Discharge Plans:					Physician Progress Notes		
	Discharge Medication List					Psychological Consults/Testing _____		
	History & Physical					Other: (Must Specify) _____		
	Medical Consults							

THIS INFORMATION NECESSARY FOR: (CHECK ALL THAT APPLY)

☐Coordination of Care/Treatment/Discharge Planning ☐Education Purposes ☐Insurance Purposes

☐Acknowledge Referral ☐Legal (must specify)_____ ☐Other (must specify)_____

I understand that I may revoke this authorization at any time 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 this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 months from the date of signing. I understand that authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization and my treatment and payment for treatment is not conditioned upon its completion. 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.

SUBSTANCE USE DISORDER INFORMATION is protected under federal regulations governing Confidentiality of Substance Use Disorder Patient Records; 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years and older is required to disclose substance use disorder information. Both the signature of the minor 13 years and younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.

A photocopy or fax of this authorization will be treated in the same manner as the original.

Signature of Patient Date Signature of Witness Date

Signature of Parent / Guardian Description of authority Date