NORTH Dakota Be Legendary.™

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NORTH DAKOTA INFORMATION TECHNOLOGY
HEALTH INFORMATION NETWORK
SFN 62228 (09-2022)

Form Approved:
Expiration Date:

See OMB Statement on Page 2.

Complete all sections, date, and sign.

I. I hereby voluntarily authorize the disclosure of information from my health record.

Name of Patient

II. The information is be disclosed by: **And is to be provided by:**

Name of Organization/Facility North Dakota Health Information Network(NDHIN consists of particip	Name of Person/Organization/Facility
Address	Address
City/State	City/State

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Educational Training
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other (Specify): _____

IV. The information to be disclosed from my health record: *(Check appropriate box(es))*

☐ Only information related to *(specify)*: _____
☐ Only the period of events from: _____ to _____
☐ Other *(specify, CHS, Billing, etc.)*: _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(other than psychotherapy notes)*
☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

V. I understand that I may revoke this authorization in writing submitted at any time to the North Dakota Health Information Network except to the extent that action has been taken on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. *Specify new date:* _____

I understand that NDHIN (which is not a health care provider) will not condition treatment or eligibility for care on my providing this authorization except if such care is: 1) research related or 2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

Signature of Patient or Personal Representative *(State relationship to Patient)*	Date
Signature of Witness *(If signature of patient is a thumb-print or mark)*	Date

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal Agency under false pretenses shall be guilty of a misdemeanor [5 USC 552a(i)(3).

Patient Identification	Name (Last, First, MI)	Record Number
	Address	
	City/State	Date of Birth

PSC Publishing Services (301) 443-6740 EF

Instructions for Completing NDHIN Form - AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.

2. Section I, print your name or the name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g. disability claim, continuing medical care, legal, research-related projects, educational training, etc.

5. Section IV, check the appropriate box as applicable.
   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   b. **Only the period of events from** -- specify date range, e.g. Jan. 1, 2002 to Feb. 1, 2002.

   c. **Other *(specify)*** -- e.g. CHS, Billing, Employee Health.

   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/ referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes.)

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/ REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**

   f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF THE OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversion considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

6. Section V, if a different *expiration* date is desired, specify a new date.

7. Section V, please sign (or mark) and date.

8. A copy of the completed NDHIN form will be given to you.

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 20 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to North Dakota Health Information Network, 4201 Normandy St, Bismarck ND, 58503. Phone: (855) 760-0534. Please DO NOT SEND this form to this address.