Jones PT – Fax 423-220 1

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

[redacted] Maiden/Other Name: _____

[redacted] _____

I authorize release of information from:

Sanford Dr. Mees

✓ Jones PT – Refused by Katelyn

_____

To be released to:
Core Health Strategies, PLLC
311 N. Mandan Street Suite 1
Bismarck, ND 58501
701.751.4464 (ph)
701.751.3947 (fax)
info@corehealthstrategies.com (email)

PURPOSE OF THIS REQUEST (required) ☒ Medical Appointment_____ Date needed by: _____

INFORMATION TO BE RELEASED:

✓ last 2 years medical history & 1 year lab & x-ray reports

_____ other (please be specific) _____

Records that are of sensitive nature will not be released unless specifically authorized below.
Any patients 14 years or older must authorize the release of their own sensitive information.

Psychiatric/Mental Health/Chemical Dependency _____ Date: _____

Contraception/STDs (if ages 14-17) _____ Date: _____

I understand that if records are released to someone who is not a healthcare provider, health plan or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may be further disclosed without obtaining my authorization.

I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form by contacting the staff of Core Health Strategies, PLLC at (701) 751-4464.
I understand that if I sign this authorization, I have a right to receive a copy of this form if requested.
I understand that I am under no obligation to sign this form and the action requested in the release will no be executed without a signature.
However, our medical treatment of the patient is not conditional on the signing or failure to sign this form. This authorization is effective for one year unless otherwise specified as follows: _____.
I understand I may cancel this authorization at any time by written notification. I am aware that my withdrawal will no be effective to uses and/or disclosures of my health information that may have already been released. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the staff of Core Health Strategies, PLLC at (701) 751-4464.
I understand that Core Health Strategies, PLLC will not receive payment in connection with the use or disclosure of my health information, unless specified here: _____. This does not apply to a reasonable fee for copying and mailing when releasing records directly to the patient. There is no charge if medical records are released to a physician, hospital, clinic, or other medical facility for continued care purposes. Please ask the staff at Core Health Strategies, PLLC at (701) 751-4464 to see the printing fees for releasing records directly to the patient.

I have had an opportunity to review and understand the contents of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes. I release the staff of Core Health Strategies, PLLC from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

[redacted]

Date: 1-15-2021

_____
If not present, state relationship – proof may be required

_____
Witness