MEDICAL INFORMATION RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH DATA

To: Any Privacy Officer/Health Care Professional

I hereby authorize you to furnish a copy of my records in your possession to, or allow those records to be inspected and/or copied by the North Dakota Board of Medicine, its agents, agents of the Attorney General's Office representing the Board, and any other appropriate state or federal governmental agencies as allowed by law.

I further authorize you, as a health care professional, to testify without limitation as to any and all of your findings and/or treatment referred to in said records and authorize the Board to use the information you provide along with the records in any legal proceeding which may arise out of this matter.

I release you, the North Dakota Board of Medicine, its agents and the agents of the Attorney General's Office representing the Board from Liability for so releasing said records or so testifying, and waive any privileges afforded me by the law relating to disclosure or introduction into evidence of this health information.

I understand subsequent release of this information may result in the information no longer being protected by the HIPAA Privacy Rule (45 Code of Federal Rules 164).

A photocopy of this form is as valid as the original. This authorization expires at the end of one year from the date of consent, unless expressly revoked in writing earlier. Revocation does not limit the Board's use of the information obtained prior to the date of revocation.

Print or Type Patient's Full Name

Signature of Patient or Patient's legal representative

Address

Date

Patient's Date of Birth