Ray Family Medical Center **Phone 701-568-2796**
10 Main Street, Ray, ND 58849 **Fax 701-568-5649**

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

I authorize the release of information from:
_____
_____
_____

To be released to:
Ray Family Medical Center
10 Main Street
Ray, ND 58849

The following information from my medical record for the time period: 2018 to 2021

- ☒ Clinic Chart Notes ☐ Pathology Report ☐ Immunization Records
- ☒ Radiology Report ☒ Laboratory Report ☐ ER report
- ☒ EKG Report ☐ Other _____

Information to be sent by:

- ☐ Mail to: PO Box 798, Ray, ND 58849 ☐ Pick up by: _____
- ☒ Fax to: 701-568-5649 ☐ Review the record on-site

Purpose of request:

- ☒ Continue medical care ☐ Insurance/Billing ☐ Other_____

This authorization shall remain in effect for three years from the date of request in accordance to ND state law, unless otherwise specified. _____

If you are the patient's legal representative, describe the scope of your authority to act on the patient's behalf.

- ☐ Parent ☐ Durable power of attorney for health care (attach)
- ☐ Other _____ ☐ Legally authorized representative of estate (attach)

1. This authorization remains in effect until the above date unless specifically revoked by written notice to RFMC. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I may request a copy of this authorization form once I have signed it. A photocopy of this authorization is as effective as the original.

_____ _____ _____
Signature of patient (18 yrs or older) or legal representative Relationship Date