LANDMARK OCCUPATIONAL HEALTH CLINIC

Physical Address: 310 Airport Rd, Ste 2000, Williston, ND 58801
Tel 701-355-6633 Fax 701-354-4865
Gary L. Moffitt, MD Paige Torgerson, DPT Misty Falcon, NP Dalana Rice, APRN

Authorization for Use and Disclosure of Protected Health Information

Date:_____ Patient Name: _____ DOB: _____

FROM: I understand that I am giving authorization and consent for (enter name and address of provider or entity you want to send your records)

Name: _____

Address/City/State/Zip:_____

TO: Release all my medical records and medication information to (enter name of provider or entity you want to receive your records)

Name: _____

Address/City/State/Zip:_____

Tel: _____ Fax: _____

Time Limit & Right of Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 310 Airport Road, Suite 2000, Williston, ND 58801. Unless revoked, this authorization will expire one year from the date of signature. I understand that this consent can be revoked at any time if requested in writing.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release. I understand that my medical or billing record may contain information in reference to drug or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C Testing, HIV/AIDS testing and/or sensitive information, I agree to its release.

Re-disclosure: I understand that the information used or disclosed pursuant to an authorization may be subjected to redisclosure by the recipient and no longer be protected by HIPPA Privacy Rules _____(Initials of patient)

I hereby release LOHC/Medical provider from all legal responsibility or liability that may arise from this act I have authorized.

Patient's Signature: _____ Date: _____

LOHC Employee Witness: _____ Date: _____