Western Plains
PUBLIC HEALTH
403 Burlington Street SE
Mandan, North Dakota 58554
701-667-3370 ● Fax: 701-667-3371

Serving: Grant ● Mercer ● Morton ● Oliver ● Sioux Counties

Authorization for Use or Disclosure of Protected Health Information (PHI)

This form authorizes Western Plains Public Health (WPPH) to use and disclose your protected health information. Please complete this form in its entirety. Contact WPPH's Privacy Officer at 701-667-3370 if you have questions in relation to this authorization.

Name	Date of Request	
Street Address		
City	State	Zip Code
Telephone Number	Date of Birth	

I authorize WPPH staff to disclose the following protected health information to:

Receiving Party's Information (Name of Person, Doctor, Clinic, or Hospital, etc.): _____

_____

Fax Number(s): _____

Description of the information to be used or disclosed.

☐ Complete Medical Record (includes all clinic notes, lab results, and imaging reports)
☐ Medical information ONLY related to: _____
☐ Records restricted to the following date range: From_____ to _____
☐ Specific records only (e.g., x-ray reports, lab results, immunization records): _____

This protected health information is being used or disclosed for the following purposes:

☐ At the request of the patient / Personal use
☐ Continued medical care / Transfer of care
☐ Other:_____

This authorization is in effect until (please choose one):

☐ Date [mm/dd/yyyy]: _____
☐ Upon sending a written revocation to WWPH
☐ Other: _____

I understand that I have the right to revoke this authorization at any time by sending a written notification to the Privacy Officer, 403 Burlington St SE, Mandan, North Dakota 58554.

I understand that a revocation is not effective to the extend that WPPH staff has relied on the use or disclosure of the protected health information.

I understand that the party receiving this information may disclose it with others, so the information disclosed may no longer be protected by federal or state law.

We will not condition your treatment on whether you provide this authorization for the requested use or disclosure.

You are not required to sign this authorization form. If you do sign this form, you have a right to receive a copy of the completed authorization.
☐ Please provide me with a copy of this authorization form.

Signature of Individual or Personal Representative_____ Date _____

Personal Representative Print Name: _____

Relationship to Individual: ☐ Parent/Guardian ☐ Spouse ☐ Power of Attorney (POA) ☐ Other:_____