

Take Care Health Systems, LLC
4165 30th Avenue Southwest, Fargo, ND 58104
Phone: 1-866-Take Care (1-866-825-3227) Fax: (701) 277-0352

AUTHORIZATION – FOR RELEASE OF INFORMATION TO THIRD PARTY

This Take Care Health Authorization is for use if you are authorizing the release of information to a third party, such as a housing authority, insurance company, or law office.

If you are requesting Take Care Health to release information to yourself, do not use this form. Please complete the "Request to Access, Inspect, or Obtain Protected Health Information" form.

Section 1: Patient Information

Patient Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip: _____
Telephone #: _____ Email Address: _____

Section 2: Person/Organization authorized to receive information from Take Care Health

Name: _____
Company: _____
Address: _____
City, State, Zip: _____
Telephone #: _____
Fax #: _____

Relationship: Spouse Parent Child Caregiver Other: _____

Section 3: Describe or list the information that you are asking us to release

Section 4: List the specific purpose for requesting this information

Section 5: Expiration Date

This authorization expires [specify date or event]:

*For Maryland residents only: This Authorization will expire one (1) year from the date listed below in Section 7.

Section 6: Information regarding this Authorization

- You have the right to revoke this Authorization, in writing to Take Care Health, at any time. The revocation is only effective after it is received and logged by Take Care Health Systems. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information (PHI). You may obtain copy of this Notice from Take Care Health or on www.takecarehealth.com. Please keep a copy of this authorization for your records.
- Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or the patient's personal representative/guardian to include a description of that person's ability to act on behalf of the patient.

Section 7: Signature

I, _____, by signing below, authorize Take Care Health to use or disclose of protected health information as described above.

Signature

Date

Section 8: If this Authorization is signed by the patient's personal representative, please explain your authority to act

Section 9: Mail this completed and signed form to:

Take Care Health Systems
Attn: PSC – Release of Information
4165 30TH Avenue Southwest, Fargo, ND 58104
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