AUTHORIZATION FOR RELEASE OF INFORMATION

NORTH DAKOTA BOARD OF NURSING
SFN 51993 (06-14)

ND Board of Nursing
919 S 7th St, Suite 504
Bismarck, ND 58504-5881
compliance@ndbon.org
701-328-9775

Name of Releasor (Last, First, Middle Initial)	Social Security Number	Date of Birth	
Street Address	City	State	Zip Code

RELEASE AND SIGNATURE

1. I hereby authorize the release of information between the North Dakota Board of Nursing
AND

Name of Person/Agency (and any employee providers of medical or health services)	Telephone Number	Fax Number	
Address	City	State	Zip Code

2. The following verbal and/or written information may be disclosed:

- ☐ Chemical Dependency Evaluation/Assessment/Recommendations
- ☐ Communication exchange in verbal and written form
- ☐ Computerized/Electronic Records
- ☐ Discharge or Treatment Summary
- ☐ Educational Evaluation/Reports
- ☐ Employment Records
- ☐ Laboratory Reports
- ☐ Legal History/Reports
- ☐ Mental Health Records
- ☐ Other (Specify) _____

_____

- ☐ Monitoring and Compliance Data
- ☐ Notice of Initial Contact
- ☐ Physical Examination
- ☐ Program Agreement
- ☐ Psychiatric Evaluation/Reports
- ☐ Psychological Evaluation
- ☐ Results of any Drug Screening
- ☐ Treatment Progress Reports
- ☐ Entire Record (Identify Time Frame) _____

3. The information identified above will be used for: (Be specific)

- ☐ Coordination of Services
- ☐ Employment
- ☐ Evaluation and Program Determinations
- ☐ Follow-up Treatment
- ☐ Other (Specify) _____

_____

- ☐ Legal Proceedings
- ☐ Obtaining Collateral Information
- ☐ Pending Administrative Matter
- ☐ Referral

4. This release of information consent remains in effect until completion of pending administrative matter **OR**

_____ (Date or Specific Event Terminating Operation of the Release)

RELEASOR CONSENT:
This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked at any time by written notice to the agency or person. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this release is as effective as the original.

I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.

Signature of Releasor	Date

I understand that my records may be confidential and protected by state or federal law and cannot be disclosed without this written consent unless otherwise provided in state or federal regulations. I understand that if the person or agency that receives the information is not a health care provider or agency covered by federal privacy regulations, the information described above may be redisclosed. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand.