Public Health
Prevent. Promote. Protect.

AUTHORIZATION FOR RELEASE OF INFORMATION

Southwestern District Health Unit

227 16th Street West
DICKINSON, NORTH DAKOTA 58601-4675
Phone (701)483-0171 or 1-800-697-3145 Fax (701) 483-4097

Name of Client (Last, First, Middle Initial)	Social Security No.	Birth date	
Street Address	City	State	Zip Code

CLIENT RELEASE AND SIGNATURE

1. 1 Hereby Authorize: (Name and Address of Person/Agency)

   Southwestern District Health Unit, 227 16th Street West, Dickinson ND 58601

2. To Release Information To: (Name and Address of Person/Agency to Receive Information)

3. The Following Information Is Requested: (Be Specific)

4. The Information Identified Above Will Be Used For: (Be Specific)

5. This release of information consent remains in effect until: One year from permission date or

(Specific Event Terminating Operation of the Release)

CLIENT CONSENT:
This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked 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.

Signature of Client	Date
Signature of Parent/Guardian or Custodian (if needed)	Date
Signature of Witness	Date

DISTRIBUTION:
ORIGINAL Requesting Agency
CANARY Southwestern District Health Unit
PINK Client

Effective 4/2003; Updated 6/2016