Authorization for Disclosure of Protected Health Information

Patient's Name _____

Patient's Medical Record Number _____

Or Affix Label

Patient Name: _____ Maiden/Previous Names: _____

Full Address: _____

Date of Birth: _____ Phone Number: _____

E-mail Address: _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:	Release Information To:
Name/Facility: _____	Name/Facility: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Purpose of Release

☐ Continuing Medical Care ☐ Work Comp ☐ Disability Determination ☐ Personal

☐ Insurance Claim ☐ Application for Insurance ☐ Legal ☐ Other: _____

Delivery Method: Date information desired by: _____

Release Format (Check only 1 option):

1. ☐ Paper via ☐ Mail OR ☐ Pick Up OR ☐ Fax (as appropriate) Fax #: _____
2. ☐ USB via ☐ Mail OR ☐ Pick Up
3. ☐ Electronic via *My Sanford Chart Patient Portal* ☐ Release to ALL My Sanford Chart Proxies ☐ Email to above address

Information to be Released

Serves Dates: From: _____ To: _____ AND all future records until authorization expires

Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

☐ Discharge Summary	☐ ER Records	☐ History & Physical	☐ Clinic Visit Notes
☐ Psychological Evals/Assmts	☐ EKG/Cardiology Reports	☐ Immunization Records	☐ Operative Reports
☐ Lab/Pathology Reports	☐ Radiology Images	☐ Radiology Reports	☐ Entire Medical Record
☐ Billing Statements	☐ Alcohol/Drug Treatment Records		(charge may apply)
☐ Hospital Claim Forms	☐ Clinic Claim Form	☐ Other:_____	

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ Do **not** release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:** _____**.** If the patient is 17 years of age or younger, the parent or legal guardian must sign & date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____ Time: _____

Relationship of Person signing (if not patient): _____