AUTHORIZATION FOR USE OR DISCLOSURE OF / ACCESS TO PROTECTED HEALTH INFORMATION

Check (✓) Facility:

☐ CHI St. Francis Health ☐ CHI Lakewood Health ☐ CHI Lisbon Health
☐ CHI Mercy Health ☐ CHI Oakes Hospital ☐ CHI St. Alexius Health - Carrington
☐ CHI St. Alexius Health - Dickinson ☐ CHI St. Alexius Health - Williston ☐ CHI St. Joseph's Health
☐ Clinic (Specify) _____ ☐ Other (Specify) _____

I, _____, hereby authorize above checked Facility(s)
(Print Name of Individual [i.e., patient, resident or client])
to use and disclose the protected health information as described below for the following patient:

Patient Name		Date of Birth
Patient Previous / Other Name(s)		
Street Address		Phone
City	State	Zip Code

I authorize the following person(s) or organization to receive the information:

Name		
Street Address		
City	State	Zip Code
Phone / Fax		Email Address* (Required for an Electronic Release)

The following individually identifiable health information may be used and/or disclosed:
(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.)
Check (✓) all that apply:

☐ Abstract (Includes[1]) ☐ Emergency Room Records ☐ Lab Reports
☐ Discharge Summary/Final Diagnosis[1] ☐ Immunization (shot) Record ☐ Physical Therapy Notes
☐ History and Physical Records[1] ☐ Radiology (i.e., X-ray) Reports ☐ Physical Notes
☐ Consultation Reports[1] ☐ Other Diagnostic Reports ☐ Medication List
☐ Operations and Procedures[1] ☐ Diagnostic Images (Prepped by Radiology Department) ☐ Itemized Bill
☐ Results of Diagnostic Testing[1] ☐ Other _____

Dates of treatment to be released:	From:	To:
Reason or purpose for the use and/or disclosure of the information:		

I request the form of release of information be:

☐ Electronic (HIM Department Portal) (*Email Needed) ☐ Paper (U.S. Mail or pick up)
☐ Other (USB, etc.**): _____ (**Device must be provided by the facility.)

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I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Prohibition on Conditioning of Authorization: The health care provider will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third-party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-Disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire one year from the date signed unless the facility receives a Revocation as outlined below.

Revocation: I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the CHI Entity specified on this release or completing the "Revocation of Authorization" form. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is Binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the facility's Notice of Privacy Practices.

I understand a fee may be charged for copies of my medical record.

If this authorization is for marketing by the covered entity, indicate if the covered entity will receive compensation for the use and disclosure of protected health information. ☐ Yes ☐ No

Signature of Individual or Personal Representative	Date (Required)	Time ☐ a.m. ☐ p.m.
Printed Name of Individual's Personal Representative (if applicable)		
Rationale for Serving as Personal Representative to the Individual (e.g., parent, legal guardian)		

(Please include supporting documentation such as Power of Attorney documents, or other documents establishing status as Personal Representative, when applicable.)