CHI St. Alexius Health

Imagine better health.℠

In order to process your request for medical records, please complete all the highlighted fields on the 'Authorization for Release of Information' form. Please pay careful attention to complete all highlighted areas of the form. If not completed, we may need to return your request for more information.

Please call 701-652-7185 with questions about release of medical records or if you need assistance completing the authorization form.

Once you have completed and signed the form(s), utilize one of these options:

- Fax it to: 1-701-652-3030
- Mail it to:

  CHI St Alexius Health Carrington
  HIM Department
  800 N 4th St
  Carrington, ND 58421

  Return it to the facility entrance greeters and the authorization will be hand delivered to the HIM Department and your request processed.

- Email your form(s) to: Michelleheinitz@catholichealth.net

Thank you,
CHI St Alexius Health Carrington

Catholic Health Initiatives

Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health Information

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I, _____, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize _____ **[Insert Record Owner]** to use and/or disclose the individually identifiable health information as described below for the following patient:

Patient Name: _____ DOB: _____

Street Address: _____

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: _____

The following individually identifiable health information may be used and/or disclosed:

Check (✓) all that apply:

__ Abstract (Includes[1])
__ Discharge Summary /Final Diagnosis[1]
__ History and Physical Records[1]
__ Consultation Reports[1]
__ Operations and Procedures[1]
__ Emergency Room Records
__ Reports of Tests & X-rays
__ Immunization (shot) Record
__ Physical Therapy Notes
__ Outpatient Clinic Notes

__ Other*: _____

* If authorization is for *marketing*, indicate if CHI St Alexius Health Carrington will receive compensation in exchange for the use and/or disclosure of the PHI. ___ YES or ___ NO

Dates of treatment to be released: _____

I request the form of release of information be ____ Electronic (Portal) ____ Electronic (Email)
____ Paper (U.S. Mail or pick up) ____ Other (CD, etc...)_____

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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.

Reason or purpose for the use and/or disclosure of the information:

_____

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

Prohibition on Conditioning of Authorization CH St Alexius Health Carrington 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 your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire _____ (insert date, event or "once purpose stated above is served").

Revocation: I understand that I may revoke this authorization at any time by notifying **CHI St Alexius Health Carrington** 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 **CHI St Alexius Health Carrington** took before it received my revocation letter. For example, **CHI St Alexius Health Carrington** cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

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Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health Information

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 CHI St Alexius Health Carrington Notice of Privacy Practices.

***SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE:**

*_____ **DATE:** *_____

Printed name of individual's personal representative, if applicable: _____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

FOR INTERNAL PURPOSES ONLY

When **CHI St Alexius Health Carrington** is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? ___YES ___NO

Access approved? ___YES ___NO