

Authorization for Use or Disclosure of Protected Health Information

I, _____, born on _____,
(Print patient's, resident's or client's name) (Date of birth)

do hereby authorize _____ to use and/or disclose my
(Name of facility/provider)
individually identifiable health information as described below:

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

Name: _____

Street Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

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

Check (✓) all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-rays and Reports |
| <input type="checkbox"/> Face Sheets / Final Diagnosis | <input type="checkbox"/> Emergency Department Records |
| <input type="checkbox"/> Operating Room Notes | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> History and Physical Records | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Other*: _____ | |

* If authorization is for *marketing*, indicate if CHI Mercy Hospital will receive compensation in exchange for the use and/or disclosure of the PHI.

- Yes No

Dates of treatment to be released: _____

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.

If you are requesting copies of your own medical record, indicate here if you would prefer to receive them in an electronic format.

- Yes* No

*If yes, please specify format you are requesting: _____

Prohibition on Conditioning of Authorization

CHI Mercy Hospital 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., physical education 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, 42CFR 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 Mercy Hospital in writing by sending a letter to **Privacy Official, CHI Mercy Hospital, 1031 7th St NE, Devils Lake, ND 58301** or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that CHI Mercy Hospital took before it received my revocation letter. For example, CHI Mercy Hospital cannot rescind disclosures it had 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 CHI Mercy Hospital’s 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 Mercy Hospital is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel

Received by: _____

Date: _____

Was signed copy provided to the individual?

Yes No

Approved for individual access?

Yes No