

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

I, \_\_\_\_\_, [Print Name of Individual (i.e., patient, resident or client)]

hereby authorize **CHI St. Alexius Health Dickinson Hospital/Family Practice Clinic/Women's Clinic/Beach Clinic** to use and disclose the protected health information as described below for the following patient:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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\*: \_\_\_\_\_

*\*Valid Email 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:

- |  |  |
|--|--|
| <input type="checkbox"/> Abstract (Includes <sup>1</sup> )               | <input type="checkbox"/> Emergency Room Records                        |
| <input type="checkbox"/> Discharge Summary /Final Diagnosis <sup>1</sup> | <input type="checkbox"/> Lab Reports                                   |
| <input type="checkbox"/> History and Physical Records <sup>1</sup>       | <input type="checkbox"/> Radiology (for example: X-Ray) Reports        |
| <input type="checkbox"/> Consultation Reports <sup>1</sup>               | <input type="checkbox"/> Other Diagnostic Reports                      |
| <input type="checkbox"/> Operations and Procedures <sup>1</sup>          | <input type="checkbox"/> Diagnostic Images (Prepped by Radiology Dept) |
| <input type="checkbox"/> Results of Diagnostic Testing <sup>1</sup>      | <input type="checkbox"/> Immunization (shot) Record                    |
|  | <input type="checkbox"/> Physical Therapy Notes                        |
|  | <input type="checkbox"/> Physician Notes                               |
|  | <input type="checkbox"/> Medication List                               |
|  | <input type="checkbox"/> Itemized Bill                                 |

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

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 healthcare 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, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

**Expiration:** This authorization will expire 1 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 PHI.     Yes    No*

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**SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE**

**DATE (Required)**

\_\_\_\_\_  
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 the personal representative, when applicable.)