



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

<input type="checkbox"/> CHI St. Alexius Health Williston Medical Center
<input type="checkbox"/> CHI Craven Hagen Clinic
<input type="checkbox"/> CHI Williston Specialty Clinic
<input type="checkbox"/> CHI Leonard P. Nelson Cancer Center
<input type="checkbox"/> CHI Health Facility (Specify) _____ <input type="checkbox"/> CHI Health Facility (Specify) _____

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

<b>Patient Name</b>		<b>Date of Birth</b>
<b>Street Address</b>		<b>Phone</b>
<b>City</b>	<b>State</b>	<b>Zip Code</b>

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

<b>Name</b>		
<b>Street Address</b>		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Phone</b>	<b>Fax</b>	<b>Email</b>

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

<b>Dates of Treatment to be released:</b>	<b>From:</b>	<b>To:</b>
<b>Reason or purpose for the use and/or disclosure of the information:</b>		

**I request the form of release of information be:**

- Electronic (Portal)
  Paper (U.S. Mail or pick up)
  Electronic (Secure Email)



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Other (USB, etc. **\*\*** \_\_\_\_\_ **\*\*Device must be provided by the facility**

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, 42CFR 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

<b>SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE</b>	<b>DATE (Required)</b>
<b>Printed name of individual’s personal representative, if applicable:</b>	
<b>Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):</b>	
(Please include supporting documentation such as Power of Attorney documents, or other documents establishing status as personal representative, when applicable.)	