

Authorization for Disclosure of Protected Health Information

Patient Name: _____
Date of Birth: _____
Full Address: _____
Maiden/Previous Names: _____
Email Address: _____ Phone Number: _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility:
Address:
City/State/Zip
Phone:

Release Information To:

Name/Facility:
Address:
City/State/Zip
Phone:

Purpose of Release:

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Personal
<input type="checkbox"/> Insurance Claim	<input type="checkbox"/> Application for Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Other: _____

Delivery Method: Date information desired by: _____

Release Format (Check only 1 option):

- Paper via Mail **OR** Pick Up **OR** Fax (as appropriate) Fax #: _____
- USB Mail **OR** Pick Up
- Electronic via My Sanford Chart Patient Portal Release to ALL My Sanford Chart Proxies Email to above email address

Information to be Released:

Service Dates: From: _____ To: _____	AND <input type="checkbox"/> all future records until authorization expires		
<input type="checkbox"/> Abstract (history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> ER Records	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Clinic Visit Notes
<input type="checkbox"/> Psychological Evals/Assmts	<input type="checkbox"/> EKG / Cardiology Reports	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Lab / Pathology Reports	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Entire Medical Record (charge may apply)
<input type="checkbox"/> Billing Statements	<input type="checkbox"/> Alcohol/Drug Treatment Records		
<input type="checkbox"/> Hospital Claim Form	<input type="checkbox"/> Clinic Claim Form	<input type="checkbox"/> Other: _____	

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ Do **not** release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless**

I specify a different event, purpose or alternative expiration date here: _____

Signature: _____ Date: _____ Time: _____

Relationship of Person Signing (If not patient): _____

