

AUTHORIZATION FOR RELEASE OF RECORDS OF PROTECTED HEALTH INFORMATION



ST. ANDREW=S HEALTH CENTER #13A
316 OHMER STREET
BOTTINEAU, ND 58318
701-228-9300

PATIENT:

(Name of Patient/Previous Name)

(Birth Date/Medical Record Number)

AUTHORIZES:

TO RELEASE PROTECTED HEALTH INFORMATION TO:

(Individual/Facility/Agency)

(Individual/Facility/Agency)

(Address)

(Address)

(City, State, Zip Code)

(City, State, Zip Code)

INFORMATION TO BE DISCLOSED/REQUESTED: (please check all being requested)

- | | | |
|---|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Radiology/ECG Reports |
| <input type="checkbox"/> Physician/PA Notes | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Operative And/Or Pathology | <input type="checkbox"/> Physicians Orders |
| <input type="checkbox"/> Other (ex: billing/financial data, please specify) _____ | | |

For The Following Date(s) Of Service: _____

THIS INFORMATION IS BEING REQUESTED/DISCLOSED FOR:

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Continuation of Medical Care | <input type="checkbox"/> Legal Investigation/Action | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Changing Health Care Provider | |
| <input type="checkbox"/> Other (specify below) _____ | | |

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my permission.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- X **Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting **St. Andrew=s Health Center Medical Record Department.**
- X **Right to Receive a Copy of this Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- X **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
- X **Right to Withdrawn This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact **St. Andrew=s Health Center Medical Record Department.** I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: I understand this authorization remains valid for a period of one (1) year or until the following specified date(s) or event_____.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

PATIENT SIGNATURE:_____ Date:_____

If patient is unable to sign - parent/guardian/legal representative sign below:

_____ Authority of Signature:_____ Date:_____

Records Pertaining to HIV/AIDS/AIDS Related Illnesses, Psychiatric/Mental Health, Alcohol/Drug Abuse, Sexually Transmitted Disease will not be released unless specifically authorized below in writing in compliance with North Dakota State statutes:

- ___HIV/AIDS/AIDS Related Illnesses ___Psychiatric/Mental Health
- ___Alcohol/Drug Dependency ___Sexually Transmitted Disease
- ___Other (Specify)_____

PATIENT SIGNATURE:_____ Date:_____

If patient is unable to sign - parent/guardian/legal representative sign below:

_____ Authority of Signature:_____ Date:_____

- disclaimer:** Records provided in this authorization which have been generated by St. Andrew=s Health Center are certified to be true and accurate. Records which may be included that have been generated by a facility/provider/organization other than St. Andrew=s Health Center cannot be certified by St. Andrew=s Health Center to be true and accurate.