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:	**Release Information To:**
Name/Facility: ______________________	**Name/Facility:** ______________________
Address: ______________________	**Address:** ______________________
City/State/Zip ______________________	**City/State/Zip** ______________________
Phone: ______________________	**Phone:** ______________________

Purpose of Release:

☐ Continuing Medical Care ☐ Work Comp ☐ Disability Determination ☐ Personal
☐ Insurance Claim ☐ Application for Insurance ☐ Legal ☐ Other: ______________________

Delivery Method: **Date information desired by:** ______________________________

Release Format (Check only 1 option):
1. ☐ Paper via ☐ Mail **OR** ☐ Pick Up **OR** ☐ Fax (*as appropriate*) **Fax # :** ______________________
2. ☐ USB ☐ Mail **OR** ☐ Pick Up
3. ☐ 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** ☐ all future records until authorization expires

☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

☐ Discharge Summary	☐ ER Records	☐ History & Physical	☐ Clinic Visit Notes
☐ Psychological Evals/Assmts	☐ EKG / Cardiology Reports	☐ Immunization Records	☐ Operative Reports
☐ Lab / Pathology Reports	☐ Radiology Images	☐ Radiology Reports	☐ Entire Medical Record (*charge may apply*)
☐ Billing Statements	☐ Alcohol/Drug Treatment Records		
☐ Hospital Claim Form	☐ Clinic Claim Form	☐ 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): ______________________________

SANFORD HEALTH

Release of Information
(Encounter)