

Date needed by: _____

To be picked up

To be mailed

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION



Patient Identification	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City/State/Zip: _____ Maiden/Previous Names/Nickname: _____ Social Security Number: _____
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Provider (Who is releasing information?)	Provider/Facility Name: _____ Address: _____ Phone: _____ City/State/Zip: _____
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Disclose Information To: (Where is information to be sent?)	Name/Facility: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____ To assure confidentiality, it is the policy of Sanford Health to send records via first-class mail. Sanford Health will transmit records via facsimile only when requested and expressly authorized by the patient.
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Information to be Disclosed	<input type="checkbox"/> Clinic Progress Notes <input type="checkbox"/> Lab Data <input type="checkbox"/> All Records <input type="checkbox"/> Physician's <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Other <input type="checkbox"/> Nurse's <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> EKG/Cardiology Reports <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Immunization Record
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Purpose of Disclosure (Please Be Specific)	<input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Consult / Second Opinion <input type="checkbox"/> Out of town move <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other (Specify) _____ For marketing: The disclosing organization <input type="checkbox"/> will <input type="checkbox"/> will not receive compensation, monetary or otherwise, as a result of this use or disclosure.
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Expiration Date	This authorization will expire one year from the date of signature or on _____.
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Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.
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Authorization	<p>I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.</p> <p>_____ Signature of patient/representative Signature Date</p> <p>_____ (Relationship to patient, if signed by representative) (Witness - optional)</p> <p>Please supply proof of authority to act. For minors, proof only required if other than parent.</p>
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Disposition	For office use only: Date sent: _____ Sent by: _____ <input type="checkbox"/> Authority to act attached <input type="checkbox"/> ID Validated MR# _____
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