Authorization for Disclosure of Protected Health Information

Patient Name:_____

Date of Birth:_____

Full Address:_____

Maiden/Previous Name:_____

Email Address:_____ **Phone Number:**_____

Release Information **FROM:**

☐ **Sanford Health**
Includes all Sanford Health System locations
☐ **Other** - *specify organization, facility, provider below:*

Name

Street Address

City

State Zip Code

Phone Fax

Release Information **TO:**

Specify organization, department or individual below:

Name

Street Address

City

State Zip Code

Phone Fax

Purpose of Release:

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

Delivery Method: (Select One) **Date Information Needed by:**_____

☐ MySanford Chart ☐ Release to My Sanford Chart Proxies also
☐ Secure Email (will be sent to above email address unless otherwise specified)
☐ USB Flash drive (electronic release)
☐ Fax (continuation of care only) to fax # listed above
☐ Paper (will be sent via USPS mail unless picked up as noted)
☐ Pick-up at a Sanford Location

Information to be Released:

Service Dates to be released: 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
☐ Lab / Pathology Reports ☐ EKG / Cardiology Reports ☐ Immunization Records ☐ Operative Reports
☐ Itemized Billing Statements ☐ Radiology Reports ☐ Radiology Images ☐ Legal Medical Record (*charge may apply*)
☐ Hospital Claims (UB) ☐ Alcohol/Drug Treatment Records
☐ Clinic Claims (HCFA 1500) ☐ 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):_____