Kittson HEALTHCARE

Authorization for Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Full Address: _____

Maiden/PreviousName: _____ **EmailAddress:** _____

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: _____ **Fax:** _____

Release Information To:

Name/Facility: _____

Address: _____

City/State/Zip: _____

Phone: _____ **Fax:** _____

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 this authorization expires

Note: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____.

☐ 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.

Signature: _____ **Date:** _____ **Time:** _____

Printed Name and Relationship of Person Signing (If not patient): _____