Authorization for Disclosure of Protected Health Information

RIVERVIEW HEALTH
Exceptional People. Exceptional Care.

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

Full Address: _____

Phone Number: _____

Maiden/Previous Names: _____

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:

Release Information To:

Name/Facility:

Address:

City/State/Zip

Phone:

Purpose of Release:

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

Delivery Method: Date information desired by: _____

Release Format (Check 1 of 3 options only):

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 ☐ Verbal
   ❑ Release to ALL *My Sanford Chart* Proxies

Information to be Released:

Service Dates: From: _____ To: _____ **OR** ❑ 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
❑ Billing Statements ❑ Other: _____ *(charge may apply)*
❑ Alcohol/Drug Treatment Records _____

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 *(required)*:	**Date Signed** *(required)*:
Printed Name of Person Signing (If not patient):	