AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ST. ANDREW=S HEALTH CENTER **#13A**
316 OHMER STREET
BOTTINEAU, ND 58318
701-228-9300

PATIENT:

_____ _____

(Name of Patient/Previous Name) (Birth Date/Medical Record Number)

AUTHORIZES: **TO RELEASE PROTECTED HEALTH INFORMATION TO:**

_____ _____
(Individual/Facility/Agency) (*Individual/Facility/Agency)*

_____ _____
(Address) *(Address)*

_____ _____
(City, State, Zip Code) *(City, State, Zip Code)*

INFORMATION TO BE DISCLOSED/REQUESTED: (**please check all being requested)**

___History and Physical ___Consultation Report ___Radiology/ECG Reports
___Physician/PA Notes ___Immunization Records ___Laboratory Reports
___Discharge Summary ___Nurses Notes ___Physical Therapy
___Emergency Room ___Operative And/Or Pathology ___Physicians Orders
___Other (ex: billing/financial data, please specify) _____

For The Following Date(s) Of Service:_____

THIS INFORMATION IS BEING REQUESTED/DISCLOSED FOR:

___Continuation of Medical Care ___Legal Investigation/Action ___Personal
___Insurance Eligibility/Benefits ___Changing Health Care Provider
___Other (specify below)
_____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my permission.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

X **Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting **St. Andrew=s Health Center Medical Record Department.**

X **Right to Receive a Copy of this Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

X **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

x **Right to Withdrawn This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact **St. Andrew=s Health Center Medical Record Department.** I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health

information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: I understand this authorization remains valid for a period of one (1) year or until the following specified date(s) or event_____.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

PATIENT SIGNATURE:_____Date:_____

If patient is unable to sign - parent/guardian/legal representative sign below:

_____Authority of Signature:_____Date:_____

Records Pertaining to HIV/AIDS/AIDS Related Illnesses, Psychiatric/Mental Health, Alcohol/Drug Abuse, Sexually Transmitted Disease will not be released unless specifically authorized below in writing in compliance with North Dakota State statutes:

___HIV/AIDS/AIDS Related Illnesses ___Psychiatric/Mental Health

___Alcohol/Drug Dependency ___Sexually Transmitted Disease

___Other (Specify)_____

PATIENT SIGNATURE:_____Date:_____

If patient is unable to sign - parent/guardian/legal representative sign below:

_____Authority of Signature:_____Date:_____

- **disclaimer:** Records provided in this authorization which have been generated by St. Andrew=s Health Center are certified to be true and accurate. Records which may be included that have been generated by a facility/provider/organization other than St. Andrew=s Health Center cannot be certified by St. Andrew=s Health Center to be true and accurate.

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