AUTHORIZATION FOR DISCLOSURE **OF PROTECTED HEALTH INFORMATION**

PATIENT:

(Address)

(Name of Patient/Previous Name)

AUTHORIZES:

(Individual/Facility/Agency)

(City, State, Zip Code)

(City, State, Zip Code)

INFORMATION TO BE DISCLOSED/REQUESTED:

- <u>Consultation Report</u> History and Physical Physician/PA Notes Immunization Records
 - <u>Nurses Notes</u> Discharge Summarv

Operative And/Or Pathology Emergency Room

Other

For The Following Date(s):

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 SMP Health - St. Andrew's Hospital 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.
- Х Right to Withdrawn This Authorization - I understand written notification is necessary to cancel this authorization.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 SMP Health - St. Andrew's Hospital Medical Record **Department.** I am aware that my withdrawal will not be effective as to uses and/or disclosures of

TO RELEASE PROTECTED HEALTH INFORMATION TO:

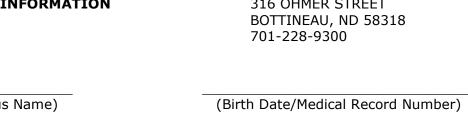
SMP Health

St. Andrew's

(*Individual/Facility/Agency*)

(Address)

Radiology/ECG Reports Laboratory Reports Physical Therapy Physicians Orders



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:

Date:	
	Date:

X 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:

PATIENT SIGNATURE:	Date:
Other (Specify)	
Alcohol/Drug Dependency	Sexually Transmitted Disease
HIV/AIDS/AIDS Related Illnesses	Psychiatric/Mental Health

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 SMP Health
St. Andrew's Hospital are certified to be true and accurate. Records which may be included that have been generated by a facility/provider/organization other than SMP Health - St. Andrew's Hospital cannot be certified by SMP Health - St. Andrew's to be true and accurate.