SMP Health St. Andrew's

#13A

AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

SMP HEALTH – ST. ANDREW'S HOSPITAL
316 OHMER STREET
BOTTINEAU, ND 58318
701-228-9300

PATIENT:

______________________________ (Name of Patient/Previous Name)

______________________________ (Birth Date/Medical Record Number)

AUTHORIZES:

____
(Individual/Facility/Agency)

____
(Address)

____
(City, State, Zip Code)

TO RELEASE PROTECTED HEALTH INFORMATION TO:

____
(Individual/Facility/Agency)

____
(Address)

____
(City, State, Zip Code)

INFORMATION TO BE DISCLOSED/REQUESTED:

___History and Physical
___Physician/PA Notes
___Discharge Summary
___Emergency Room
___Consultation Report
___Immunization Records
___Nurses Notes
___Operative And/Or Pathology
____Radiology/ECG Reports
___Laboratory Reports
___Physical Therapy
___Physicians Orders

Other____________________________________

For The Following Date(s):____

THIS INFORMATION IS BEING REQUESTED/DISCLOSED FOR:

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

____

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.

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 **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

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:_______________

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:

___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 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.