

**AUTHORIZATION FOR DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**SMP HEALTH – ST. ANDREW'S  
316 OHMER STREET  
BOTTINEAU, ND 58318  
701-228-9406**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:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Report        | <input type="checkbox"/> Radiology/ECG Reports |
| <input type="checkbox"/> Physician/PA Notes   | <input type="checkbox"/> Immunization Records       | <input type="checkbox"/> Laboratory Reports    |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Nurses Notes               | <input type="checkbox"/> Physical Therapy      |
| <input type="checkbox"/> Emergency Room       | <input type="checkbox"/> Operative And/Or Pathology | <input type="checkbox"/> Physicians Orders     |
| Other _____                                   |   |  |

For The Following Date(s): \_\_\_\_\_

**THIS INFORMATION IS BEING REQUESTED/DISCLOSED FOR:**

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> Continuation of Medical Care   | <input type="checkbox"/> Legal Investigation/Action    | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Changing Health Care Provider |                                   |
| <input type="checkbox"/> 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 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 Medical Record Department**. I am aware that my withdrawal will not be effective as to uses and/or disclosures of

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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 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 cannot be certified by SMP Health - St. Andrew's to be true and accurate.