AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient_____ Chart No._____

Date of Birth:_____ Phone #_____ Last 4 digits of Social Security # __ __ __ __ (optional)

I authorize: To release to:

_____ _____

_____ _____

_____ _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED
(specify dates for each, unless "entire medical record" is selected)

_____Sanford treatment from _____(date) to _____(date)

_____Hospital Admission Summary	_____Lab Reports	_____Pathology Report
_____Hospital Discharge Summary	_____X-ray Reports	_____Billing Information
_____Entire Medical Record for all dates	_____X-ray Films/CD	_____Immunizations
_____Progress Notes/Clinic Notes	_____Psychiatric Intake	_____Operative Report

_____Other (please specify)_____

_____

_____

☐ Verbal discussion only – do not release any written records

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:
___Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

PURPOSE OF THE USE AND DISCLOSURE

_____Further Treatment (**Date of Appointment**_____)		_____Insurance Application
_____Personal Records	_____Education	_____Disability Determination
_____Vocational Rehabilitation Evaluation	_____At my request	_____Payment of Insurance Claims
_____Legal	_____Other _____	

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Patient/Guardian/Representative Date

_____
(If not patient, state authority/relationship)