CHI St. Gabriel's Health

Imagine better health.℠

Authorization For Use or Disclosure of/Access to Protected Health Information

I, _____, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize the following facilities or locations from which you are requesting records. Please check as appropriate:

☐ **CHI St. Gabriel's Hospital** ☐ **Family Medical Center Randall**

☐ **Little Falls Ortho** ☐ **Family Medical Center Little Falls**

☐ **Family Medical Center Pierz**

Patient Name: _____ DOB: _____

Patient Previous/Other Name(s): _____

Street Address: _____Phone: _____

City: _____ State: _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email*: _____

**Valid Email required for an electronic release*

The following individually identifiable health information may be used and/or disclosed:
(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request. **)

Dates of treatment to be released: From: _____ To: _____

Check (✓) all that apply:

__ Abstract (Includes[1])
__ Discharge Summary /Final Diagnosis[1]
__ History and Physical Records[1]
__ Consultation Reports[1]
__ Operations and Procedures[1]
__ Results of Diagnostic Testing[1]
__ Emergency Room Records
__ Lab Reports
__ Radiology (for example: X-Ray) Reports
__ Other Diagnostic Reports
__ Diagnostic Images (Prepped by Radiology Dept.)
__ Immunization (shot) Record
__ Physical Therapy Notes
__ Physician Notes
__ Medication List
__ Itemized Bill

__ Other**: _____

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Reason or purpose for the use and/or disclosure of the information:
_____

I request the form of release of information be ____ *Electronic
____ Paper (U.S. Mail or pick up) ____ Other (USB, etc... ***) _____
***Device must be provided by the facility

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Prohibition on Conditioning of Authorization: The healthcare provider will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire 1 year from the date signed unless the facility receives a Revocation as outlined below.

Revocation: I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Facility's Notice of Privacy Practices.

I understand a fee may be charged for copies of my medical record.

If this authorization is for marketing by the covered entity, indicate if the covered entity will receive compensation for the use and disclosure of PHI. ___Yes ___No

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE: **DATE (Required)**

_____

Printed name of individual's personal representative, if applicable:

_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

_____