



Authorization - Release Of Medical Records Information

Patient Identification	Patient name: _____ Date of birth: _____ Address: _____ City/state/zip: _____ Social Security Number (last 4 digits): _____ Phone: _____						
Provider (Who is releasing information?)	The following individual or organization is authorized to make the disclosure: Provider name: _____ Address: _____ City/state/zip: _____ Phone: _____ Fax: _____						
Disclose Information to (Where is information to be sent?)	Name/site: _____ Address: _____ City/state/zip: _____ Phone: _____ Fax: _____						
Information to be Disclosed	<input type="checkbox"/> Standard chart copy (Includes Demographic Face Sheet, Physician Dictated Reports, All Test Results) <input type="checkbox"/> X-ray and imaging reports <input type="checkbox"/> Entire record (charges may apply) <input type="checkbox"/> Other _____						
Service Dates	Dates of service from (date) _____ to (date) _____						
Form and Format	<input type="checkbox"/> Paper (pickup or mail) <input type="checkbox"/> Fax <input type="checkbox"/> Flash Drive <input type="checkbox"/> CD-ROM (compact disc) <input type="checkbox"/> E-mail (please provide address below) E-mail address: _____ All medical records requested in electronic format will be encrypted unless specifically requested otherwise by the patient. Sending medical records unencrypted has risks including the individual's PHI could be read or otherwise accessed by a third party. File size may limit ability to send by e-mail. If you want your records sent unencrypted please initial here: _____						
Substance Abuse Documentation	<input type="checkbox"/> Check this box ONLY if you permit substance abuse records to be released. Requestor, take note: 42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE RECORDS						
Purpose of Disclosure	<input type="checkbox"/> Continued healthcare <input type="checkbox"/> Completion/payment <input type="checkbox"/> Personal <input type="checkbox"/> Other _____						
Expiration Date	Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event, or condition, this authorization shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.						
Revocation	I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to: • Information already released in response to this authorization • My insurance company when the law provides my insurer with the right to contest a claim under my policy.						
Authorization	<p>I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.</p> <p>I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Avera Medical Records at 833-821-9944 or Fax 605-322-8200.</p> <table border="0"><tr><td>_____ Signature of Patient or Legal Representative</td><td>_____ Date</td></tr><tr><td>_____ If Signed by Legal Representative, Relationship to Patient</td><td>_____ Signature of Witness</td></tr><tr><td colspan="2">Date: _____ Information sent: _____</td></tr></table>	_____ Signature of Patient or Legal Representative	_____ Date	_____ If Signed by Legal Representative, Relationship to Patient	_____ Signature of Witness	Date: _____ Information sent: _____	
_____ Signature of Patient or Legal Representative	_____ Date						
_____ If Signed by Legal Representative, Relationship to Patient	_____ Signature of Witness						
Date: _____ Information sent: _____							