Date needed by:_____
☐ To be picked up
☐ To be mailed

AUTHORIZATION
FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

SANFORD

Patient Identification

Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City/State/Zip: _____
Maiden/Previous Names/Nickname: _____
Last 4 digits of Social Security Number: _____

Provider (Who is releasing information?)

Provider/Facility Name: _____
Address: _____ Phone:_____
City/State/Zip: _____

Disclose Information To: (Where is information to be sent?)

Name/Facility: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax:_____
To assure confidentiality, it is the policy of Sanford Health to send records via first-class mail. Sanford Health will transmit records via facsimile only when requested and expressly authorized by the patient.

Information to be Disclosed

☐ Clinic Progress Notes
___ Physician's
___ Nurse's
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Lab Data
☐ Pathology Reports
☐ Radiology Reports
☐ EKG/Cardiology Reports
☐ Immunization Record
☐ All Records
☐ Other
_____
_____
_____

Purpose of Disclosure *(Please Be Specific)*

☐ Continuing Medical Care ☐ Consult / Second Opinion ☐ Out of town move
☐ Insurance Claim ☐ Legal ☐ Personal
☐ Other (Specify)_____
For marketing: The disclosing organization ☐ will ☐ will not receive compensation, monetary or otherwise, as a result of this use or disclosure.

Expiration Date

This authorization will expire one year from the date of signature or on_____.

Revocation

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Authorization

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

_____ _____
Signature of patient/representative Signature Date

_____ _____
(Relationship to patient, if signed by representative) (Witness - optional)

Please supply proof of authority to act. For minors, proof only required if other than parent.

Disposition

For office use only:
Date sent: _____ Sent by:_____
☐ Authority to act attached
☐ ID Validated
MR# _____