Authorization for Disclosure of Protected Health Information

PATIENT LABEL
or
MRN#

Patient Name: _____

Date of Birth: _____

Full Address: _____

Maiden/Previous Name: _____

Email Address: _____ **Phone Number:** _____

Release Information **FROM:**

☐ **Mahnomen Health**
Includes Hospital & Care Center

☐ **Other** - *specify organization, facility, provider below:*

Name _____

Street Address _____

City _____

State _____ Zip Code _____

Phone _____ Fax _____

Release Information **TO:**

Specify organization, department or individual below:

Name _____

Street Address _____

City _____

State _____ Zip Code _____

Phone _____ Fax _____

Purpose of Release:

☐ Continuing Medical Care ☐ Work Comp ☐ Disability Determination ☐ Personal
☐ Insurance Claim ☐ Application for Insurance ☐ Legal ☐ Other: _____

Delivery Method: (Select One) **Date Information Needed by:** _____

☐ MySanford Chart ☐ Release to My Sanford Chart Proxies also
☐ Secure Email (will be sent to above email address unless otherwise specified)
☐ CD/DVD (Radiology Images only)
☐ Fax (continuation of care only) to fax # listed above
☐ Paper (will be sent via USPS mail unless picked up as noted)
☐ Pick-up at Mahnomen Health

Information to be Released:

Service Dates to be released: From: _____ To: _____ **AND** ☐ all future records until authorization expires

☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe)*

☐ Discharge Summary ☐ ER Records ☐ History & Physical ☐ Clinic Visit Notes
☐ Lab / Pathology Reports ☐ EKG / Cardiology Reports ☐ Immunization Records ☐ Operative Reports
☐ Itemized Billing Statements ☐ Radiology Reports ☐ Radiology Images ☐ Legal Medical Record *(charge may apply)*
☐ Hospital Claims (UB) ☐ Alcohol/Drug Treatment Records
☐ Clinic Claims (HCFA 1500) ☐ Other: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____Do **not** release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:** _____

Signature: _____ **Date:** _____ **Time:** _____

Relationship of Person Signing (If not patient): _____

Instructions to complete the Patient Authorization for Release of Protected Health Information

Patient Information:
Complete the entire section clearly and legibly with all of the demographic information specific to the patient. You must be 18 years of age or the parent, legal guardian or appointed representative to request copies of your medical record. You may be asked to provide documents showing that you are the patient's legally authorized representative.

Release Information to:
When requesting records from Mahnomen Health to be sent to another health care organization, fill this section out with as much information as possible. Be specific as to where you want your health information sent (e.g., individual, business, other healthcare facility). It is best to provide a complete mailing address as not everyone will accept health information via fax.

Purpose for Release:
This section indicates reason for releasing the health information. Checking this box will assist us in tracking, assigning priority and who may be responsible for the cost of records (as appropriate). It is very helpful if you identify a date by which the requested information is needed as this helps ensure that your records will be available when you need them.

Delivery Method:
This tells us how you would like your information prepared & delivered. Multiple options are available including mail, fax, CD/DVD (imaging only), email or through online portal.

> Note: *If you choose to receive your health information via email in a non-secure manner, the information will not be encrypted and it could be viewed by a third party. Mahnomen Health is not responsible for unauthorized access of your health information while in transmission to the email address you designated. Also, there are size limitations when emailing records.*

The patient portal, via MySanford Chart, is a free & secure option for patients who prefer to receive information electronically. Online patient portal delivery is not available in proxy access situations. If you are a proxy, please request another method of delivery.

Information to be released:
This section gives us instructions for what information you want released; **use only those that apply to your specific need.** If you select "entire" medical record, we may contact you to verify exactly what information you want released. Fees may be charged in accordance with State and Federal Regulations.

Authorization
Sign and date the authorization. **Electronic signatures are not accepted**. An Authorization is valid for one year unless other specified. Services provided after the date of signature may be released according to the authorization up until authorization expires. To revoke the authorization, submit a written request to our facility.

For questions or if you need assistance completing this form, please contact us at:

Mahnomen Health Hospital
Release of Information Department
414 W Jefferson Ave
Mahnomen, MN 56557
Phone: 218-935-2511
Fax: 218-216-1922
Email: roi@mahnomenhealth.org

Mahnomen Health Hospital is a separate entity from Sanford Health Clinics & Hospitals.
Mahnomen Health ROI Department will process requests for visits and services performed in our facility only.

For record requests pertaining to visits within the Sanford Health System, please contact their ROI department directly at 701-234-2366 or log into your Sanford My Chart to access your health information.