Tyler Healthcare Center
Avera Health

ROI completed by: _____

Date completed: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

TO: _____
_____
_____

Patient Name: _____

DOB: _____ Record # _____

I authorize _____ **to release my protected health information to:**

Name/Title: _____

Organization _____

Address_____

City/Sate/Zip_____

The information is to be released for the following purpose:

___ Continuing Care ____ Litigation ____ Insurance Claim Other (specify)_____

___ At the request of the individual (check when patient elects not to disclose purpose)

Specific protected health information to be released from my medical record to include:

____ History & Physical ____ Discharge Summary ____ Operative Report

____ Pathology Report ____ Consultation Report ____ Laboratory Report

____ X-ray Report ____ Progress notes ____ other (specify)

____ Entire record_____**Electronic Health Record Requested- date requested_____

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). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Indicate the time periods (dates) for which these records are being released:

From _____ to _____

I understand I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy. 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 will expire six months from the date I signed it.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that 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 the privacy officer.

_____ Date _____ Time _____ _____

Signature of patient/personal representative — Relationship if signed by personal representative

_____ Date _____ Time _____

Witness