MR: 29 7/11/03 H – 12
R 7/04; 10/06; 11/07
Rev: 9/05; 1/09; 1/10; 2/11

Attachment: A

AVERA ST. ANTHONY'S HOSPITAL - O'NEILL, NEBRASKA

RELEASE OF PATIENT'S MEDICAL INFORMATION

Patient Name _____ **Date of Birth** ____/____/____

I authorize the following organization to release information as stated below from the patient health information record:

Information to be Released FROM:	Information to be Released TO:
☐ Avera St. Anthony's Hospital ☐ Avera Medical Group – O'Neill	☐ Avera St. Anthony's Hospital ☐ Avera Medical Group - O'Neill
☐ _____ Organization	☐ _____ Person or Organization
_____ Address City, State, Zip	_____ Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

INFORMATION TO BE RELEASED:

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Diagnostic and Screening Test Results (lab,x-ray,RT)
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Emergency Department Report
- ☐ Consultation Report
- ☐ Operative Report Photographs
- ☐ AMGO Clinic Note
- ☐ Immunization Record
- ☐ Other: _____
- ☐ All Records

REASON FOR DISCLOSURE:

- ☐ Continuation of Care/Consultation/ Follow up after ER visit
- ☐ Social Security/Disability Certification
- ☐ Insurance Claim/Application
- ☐ Attorney Inquiry/Legal Matter
- ☐ Worker's Compensation
- ☐ Personal Information
- ☐ Other: (specify) _____
  _____

DATES OF SERVICE FOR RECORDS REQUESTED: Beginning_____**Through**_____

I understand that 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 also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

REVOCATION CLAUSE:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that 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 when 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 in one hundred eighty days (180) days.

SIGNATURE:

I understand that 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 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 Medical Records Department of Avera St. Anthony's Hospital, 300 North 2nd Street, O'Neill, Nebraska, 68763 (Tel: 402- 336-2611).

Patient, Parent or Legal Guardian_____ **Date:**_____
Relationship to Patient:_____

*** FOR HOSPITAL USE ONLY ***

Date Information Released: _____
Processed By: _____
Signature of Individual Releasing Information