Avera St. Anthony's Hospital
300 N. 2nd St., P.O. Box 270
O'Neill, NE 68763
402-336-2611

ROI

Patient Sticker if available

Authorization - Release Of Medical Records Information

Patient Identification

Patient name: _____ Date of birth: _____
Address: _____ City/state/zip: _____
Social Security Number (last 4 digits): _____ Phone: _____ Email: _____

Provider (Who is releasing information?)

The following individual or organization is authorized to make the disclosure:
Provider name: Avera St. Anthony's Hospital
Address: 300 N. 2nd St., City/state/zip: O'Neill, NE 68763
Phone: 402-336-5281 Fax: _____

Consent

For: ❑ Photographs ❑ Digital Images ❑ Videotapes
❑ Other: _____

Purpose of: ❑ Permanent Part of the Patient Record ❑ Media
❑ Internal purposes, not a permanent part of the Patient Record ❑ Social Media/Networking

I understand that the images indicated above may be recorded and I consent to this.

I have the right to request cessation of recording or filming, and the right to rescind consent for use up until a reasonable time before the recording or film is used.

_____ _____ _____
Time Date Patient, Parent or Legal Guardian Signature/Relationship to Patient

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

❑ YouTube ❑ Facebook ❑ Twitter
❑ News Outlet: _____
❑ Other: _____

Information to be Disclosed

❑ Photographs ❑ Digital Images ❑ Recordings ❑ Videotapes
❑ Patient Interview – Date: _____ ❑ Other: _____

Form and Format

❑ Paper (pickup or mail) ❑ Fax ❑ Flash Drive ❑ CD-ROM (compact disc) ❑ 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: _____

Purpose of Disclosure

❑ News story ❑ Web page ❑ Internal News ❑ Avera Newsletters ❑ Social Networking
❑ Other: _____

Expiration Date

Unless otherwise revoked, this authorization will expire when this information is no longer used by the Avera Marketing Department.

Revocation

I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the Avera Marketing Department. I understand the revocation will not apply to information already released.

Authorization

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.

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 the Avera St. Anthony's Hospital Privacy Officer at 402-336-5154 or the Avera Privacy Officer at 605-322-7801.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Date: _____ Information sent: _____