Avera Sacred Heart Hospital

Rev. 4/2015

Authorization – Release of Medical Records Information

Patient Identification	Patient Name:_____ Date of Birth:_____ Address:_____Phone: _____ City/State/Zip:_____ (Maiden/Previous Names/Nickname):_____ Social Security Number:_____
Provider (Who is releasing information?)	The following individual or organization is authorized to make the disclosure: Provider Name: Avera Sacred Heart Hospital __Other Facility_____ Address: 501 Summit Phone: (605) 668-8034 City:_____ City/State/Zip: Yankton, SD 57078 Phone:_____ Fax _____ Released by HIM: ___ Released by Nursing: ___verbally ___copies
Disclose Information to: (Where is information to be sent?)	Name/Facility:_____ Address:_____ City/State/Zip:_____ Phone:_____ Fax:_____ (Avera Sacred Heart will release date and time of discharge to the Police Department upon signed authorization)
Information to be Disclosed	☐ Standard Chart Copy (includes demographics, dictated reports, all test results) ☐ Entire Record ☐ History and Physical ☐ Discharge Summary ☐ Lab ☐ X-ray and imaging reports ☐ Cardiology Reports ☐ Operative Report ☐ Pathology ☐ Billing ☐ MAR ☐ Other _____
Service Dates	Dates of Service from:_____ to _____
Substance Abuse Documentation	☐ Check this box ONLY if you permit substance abuse to be released. Requestor, take note: These released records contain substance abuse documentation and therefore prohibition on redisclosure applies. THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISION OF FEDERAL STATUSES (42 U.S.C 290dd-2 and regulation 42 CFR, part 2) which prohibits any further disclosure of this information without the specific written consent of the person to who it pertains or as otherwise permitted by such regulations.
Purpose of Disclosure	__Continued Healthcare __Completion/Payment __Personal __Other _____ (Purpose not required for personal requests) A copying fee may be charged on requests for purposes other than patient care.
Expiration Date	Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
Revocation	I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to: • Information already release in response to this authorization • My insurance company when the law provides my insurer with the right to contest a claim under my policy
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 Sacred Heart Hospital Privacy Officer at (605) 668-8040. _____ _____ Signature of patient or Legal Representative Date _____ _____ If signed by Legal Representative, relationship to patient Signature of Witness Date Information Sent:_____