Medical Record Number:

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Please fax completed form to 320-231-4833

Patient Name: _____ Birth Date: ☐☐ / ☐☐ / ☐☐☐☐

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) -

I request that my protected health information (PHI) from [ ] Rice Memorial Hospital [ ] Other _____ **be disclosed to:**

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) -

Fax: (healthcare provider only): _____

Covering the period of healthcare from: Specific Dates(s) _____ to _____ **OR** [ ] all past and present encounters/visits?

I authorize the following PHI to be released from my medical record(s): [ ] Emergency Room record [ ] Laboratory reports
[ ] Radiology reports [ ] Immunization record [ ] Pathology reports [ ] Itemized billing records [ ] operative reports
[ ] Summary (includes discharge summary, H&P, operative report(s), consultations and test results [ ] Complete medical record (all pages)
[ ] Test result(s) of: _____
[ ] Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental heath services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate)

	Yes	No	Dates
HIV Testing and Results	[ ]	[ ]	
Mental Health Records	[ ]	[ ]	
Psychotherapy Records?	[ ]	[ ]	

Purpose for requesting information: [ ] Legal [ ] Insurance [ ] Personal [ ] Continuation of Care

Disclosure Format: [ ] My Chart [ ] US Mail [ ] Fax to Family [ ] Pick-up [ ] CD
What is My Chart? Go to: http://ricehospital.com/mychart.html for information.

By signing this authorization form, I understand that:
- Requests for copies of medical records are subjest to reproduction fees in accordance with federal/state regulations
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department. Revocation will not apply to information that has already been disclosed in response to the authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condiditon: _____.
  If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

Rice Memorial Hospital shares an electronic medical record with CentraCare Health (CCH). CentraCare Health shares an electronic medical record with non-CCH organizations. Authorizing the release of the following items: Medication List, Allergy List, Problem List, Immunization Data and/or Medical History includes the release of this information from all sites that share an electronic medical record. A list of these non-CCH organizations will be provided to the patient upon request.

Revocation of Authorization

I, _____ hereby revoke this authorization to disclose health information for the following reason:_____

I understand that this does not apply to information that has already been released in response to this authorization, but will stop any further disclosure of this information.

_____ _____

Signature of Patient/Legal Representative Date of Signature

_____

Witness

Submit