Mobridge Regional Hospital and Clinics

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
[ ]MRH [ ]MMC [ ]WRHC [ ]WDHC [ ]SMC

_____ _____ _____
Name of Patient Date of Birth Medical Record #

RELEASE OF PROTECTED HEALTH INFORMATION FROM:

_____
Name of Health Care Provider / Plan / Other

_____
Street Address

_____
City, State, Zip Code

AUTHORIZES INFORMATION TO:

_____
Name of Health Care Provider / Plan / Other

_____
Street Address

_____
City State, Zip Code

INFORMATION TO BE USED / DISCLOSED:

- ☐ Clinical Resume/Discharge Summary
- ☐ History of Physical Report
- ☐ Consultation Report
- ☐ Emergency Room Record
- ☐ Pathology Report
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Other (Specify) _____
- ☐ Operative Report
- ☐ EKG Reports
- ☐ Billing Records

For the Following Dates: _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

- ☐ Further Medical Care
- ☐ Insurance Eligibility / Benefits
- ☐ Other (Specify: _____
- ☐ Legal Investigation or Action
- ☐ Changing Physicians
- ☐ Personal

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

All records pertaining to psychiatric/mental health, alcohol, and/or drug dependency, and/or HIV/HIV related illness will not be released unless specifically authorized below in writing:

I specifically authorize the release of the following records:

Psychiatric/Psychological _____ HIV _____ Drug and/or Alcohol Dependency _____
Initials Initials Initials

1. This authorization remains in effect until the above Date, Event or Condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need to sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this Authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that receives this information is not a health care provider or health plan covered by federal privacy regulation the information described above shall be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

I understand this organization **will / will not** be receiving any direct or indirect payment in connection with the use or disclosure of my health information.

EXPIRATION DATE: This authorization is good until the following Date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE:

_____ **DATE:** _____
(If signed by other than patient, state relationship <u>and</u> authority to do so.)

WITNESS: _____