WELLSTONE
REGIONAL HOSPITAL

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____ Last 4 of SS#: _____

**To be released to or requested from:**

☐ Self (address above)

☐ _____ (____)_____ _____
Individual/Agency/Organization Telephone Number Street Address

_____ (____)_____ _____
Name / Attention to Fax Number City State Zip Code

**Via (only when released to):** ☐ Mail ☐ Fax ☐ Pick-up ☐ Email: _____
☐ Verbal Exchange of Information ONLY

**I am requesting disclosure of my protected health information for the following purpose:**

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other: _____

**Dates of Service Requested**: _____

☐ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

**Only the information and records indicated below (check all that apply and /or specific if "Other is checked**):

☐ All the following:
☐ Continuity/Transition of Care Packet
☐ Psychiatric Evaluation
☐ History and Physical
☐ Discharge Summary
☐ Progress Notes
☐ Physician Orders
☐ Lab/Diagnostic Reports
☐ HIV Test Results and AIDS Treatment Records
☐ Other: _____

**This authorization will expire on ____/____/20____.** (If not indicated, authorization will expire <u>one year</u> from signature date)

**This form must be completed in full before signing:**

_____ _____ _____
Patient's signature (required for ages 14 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness signature/Credentials Date Signed

This authorization is intended to allow Wellstone Regional Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

**Right to Revoke Authorization**

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

**Revocation Signature: _____ Date: _____ Time: _____**