Mobridge Regional Hospital and Clinics

1401 10th Ave West
Mobridge SD 57601
Phone: 605-845-3693
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

[ ] MRH [ ] MMC [ ] WRHC [ ] WDHC

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:

[ ] Medical History, Examination, Provider note
[ ] Office Notes
[ ] Allergy Records
[ ] Consultations
[ ] Surgical Reports
[ ] Hospital Records including Reports
[ ] Laboratory Reports
[ ] Other (Specify) _____
[ ] Immunizations
[ ] Rad/NM/CT Reports
[ ] Prescriptions

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

I understand that if the person(s) and / or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and not all health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Department. **Right To Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I may be provided with a signed copy of the form upon request.. **Right To Refuse to Sign This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Health Information Department. I am aware that my withdrawal will not be effective as to uses and / or disclosures of my health information that the person(s) and / or organization(s) listed above have already been made in reference to this authorization.

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 and authority to do so.)

WITNESS: _____