Mobridge Regional Hospital and Clinics
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Phone: (605) 845-3692 • FAX: (605) 845-8252
www.mobridgehospital.org

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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

Patient Alias(s) _____

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
- ☐ Reproductive Healthcare (Additional attestation form required)
- ☐ HIV_____(Initials required)
- ☐ Drug and/or Alcohol Dependency _____(Initials required)
- ☐ Psychiatric/Psychological_____(Initials required)

(If requesting psychiatric/psychological records, must be requested separate from other record requests)

For the Following Dates: FROM _____ TO _____

NOTE: This authorization expires 1 year from the date of patient signature unless specified otherwise. Alternative date:_____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

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

Delivery Method:

1. ☐ Paper via ☐ Mail OR ☐ Pick Up OR ☐ Fax (as appropriate) Fax #_____
2. ☐ USB ☐ Mail OR ☐ Pick Up
3. ☐ Electronic via email _____ (Note: Records will be sent via encrypted email)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

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.

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:

(Signature required) _____ (Printed name of person signing) _____

(Date) _____ *(If signed by other than patient, state relationship and authority to do so)* _____

WITNESS: _____ DATE: _____