



Authorization for Disclosure / Release of Protected Health Information

Request #: _____

Medical Record #: _____

Complete all sections with arrows.

→ Patient's Legal Name: (PRINT) _____ **Date of Birth:** _____

→ Facility, individual, or group of individuals authorized to release information:

- | | | |
|---|--|---|
| <input type="checkbox"/> Regional Health Assisted Living | <input type="checkbox"/> Regional Health John T. Vucurevich Cancer Care Institute | <input type="checkbox"/> Regional Health Sleep Center |
| <input type="checkbox"/> Regional Health Behavioral Health Center | <input type="checkbox"/> Regional Health Lead-Deadwood Hospital | <input type="checkbox"/> Regional Health Spearfish Hospital |
| <input type="checkbox"/> Regional Health Custer Hospital | <input type="checkbox"/> Regional Health Medical Clinic
Specify Facility: _____ | <input type="checkbox"/> Regional Health Sturgis Hospital |
| <input type="checkbox"/> Regional Health Custer Senior Care | <input type="checkbox"/> Regional Health Rapid City Hospital | <input type="checkbox"/> Regional Health Sturgis Senior Care |
| <input type="checkbox"/> Regional Health Heart and Vascular Institute | <input type="checkbox"/> Regional Health Rehabilitation
<input type="checkbox"/> Center or <input type="checkbox"/> Institute | <input type="checkbox"/> Regional Health Surgery Center (SP) |
| <input type="checkbox"/> Regional Health Home+ Hospice
Specify Facility: _____ | | <input type="checkbox"/> Regional Health Urgent Care
Specify Facility: _____ |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Same Day Surgery Center |

→ Information to be disclosed:

- | | | |
|--|--|---|
| <input type="checkbox"/> Verbal Information Only <i>Specify:</i> _____ | <input type="checkbox"/> Dictated Reports | <input type="checkbox"/> Operative Summary |
| <input type="checkbox"/> Behavioral Health Inpatient Reports* Must initial below | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pain Management Notes |
| <input type="checkbox"/> Behavioral Health Outpatient Reports* Must initial below | <input type="checkbox"/> Electrocardiogram (EKG) | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Billing Information | <input type="checkbox"/> ER Chart / Dictation | <input type="checkbox"/> Patient Portal Code or Access** |
| <input type="checkbox"/> Cardiac Cath | <input type="checkbox"/> Evaluation | <input type="checkbox"/> Patient Status and progress toward discharge |
| <input type="checkbox"/> Chemical Dependency Evaluation* Must initial below | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Long Term Care Records | <input type="checkbox"/> Psychotherapy Notes* Must initial below |
| <input type="checkbox"/> Completion Note | <input type="checkbox"/> Medications | <input type="checkbox"/> Speech Therapy/Audiology Notes |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Neuropsychology Notes
* Must initial below | <input type="checkbox"/> X-Ray/CT/Nuclear Medicine** |
| | <input type="checkbox"/> Occupational Therapy Notes | <input type="checkbox"/> Other: _____ |

→ Specify date of service: _____

→ Release these records to: **Name:** _____

Address: _____

Telephone #: _____ **Fax #:** _____

→ For the purpose of: Continuing Care Insurance Legal Personal Use Other: _____

Your initials below allow the designated facility to disclose information protected under federal law relative to drug and/or alcohol treatment, psychiatric care, or, diagnosis or information specific to HIV, AIDS, or Sickle Cell Anemia.

→ I understand this will include information related to: (initial if applicable; must be initialed for disclosure of this information)

- (initials) _____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human immunodeficiency Virus) infection
- (initials) _____ Psychiatric Care
- (initials) _____ Sickle Cell Anemia
- (initials) _____ Treatment for alcohol and/or drug abuse

*Your initials above allow the designated facility to disclose information protected under federal law relative to drug/alcohol treatment, etc.

**The parent or authorized representative and the minor age 12 years or greater will co-sign the authorization to allow shared Portal access of the minor.



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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or other benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Release of Information Technicians.

I authorize the release of information as specified above. I release the above designated facility and individuals from all legal responsibility or liability, which may arise from the release of this information.

→ Patient/Legal Representative Signature: _____ **Date:** _____ **Time:** _____

Specify Relationship if Not Patient and PRINT Name: _____

→ Authorization Witnessed by Name PRINT _____

Authorization Witnessed by Signature: _____ **Date:** _____ **Time:** _____

**** Medical Imaging Services (Radiology) Disclaimer:** If you have received copies of computer digital images please be advised that this print of a computer digital image is provided exclusively as a courtesy for the patient, who is the subject of the image. **The image displayed on this document is for reference only.** If an image is needed for diagnostic purposes, have your doctor or allied health professional contact the Medical Imaging Department at Rapid City Regional Hospital.

For the recipient of this information:
If the information released contains drug and alcohol diagnosis or treatment information (as indicated above), the following applies: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Standard Fees: Reasonable charges may be applied in accordance with Regional Health's current fee schedule. You will be notified of applicable fees before your request is processed.

For Regional Health Clinics Only
The following is to be reviewed and signed by the patient.
After the physician reviews your outside records, you have the option of picking them up or allowing the clinic to dispose of them by shredding. If no indication is made, the outside records will be shredded.
 Yes, I will pick up my records after they have been reviewed.
 You have permission to shred the outside records after they have been reviewed and the physician.
Records not picked up 60 days after receipt will be shredded.

Signature: _____ Date: _____ Time: _____

To be completed by Regional Health Caregiver(s)
Photo ID Verified*Date: _____ Initials: _____
Charges Explained.....Date: _____ Initials: _____
Records Picked up.....Date: _____ Initials: _____
Records SentDate: _____ Initials: _____
Records Faxed.....Date: _____ Initials: _____
Pick Up X-Ray FilmsDate: _____ Initials: _____
To be picked up onDate: _____ Initials: _____
Complete the Disclosure Tracking Log when required and retain in patient record.
* Policy COC-8217-118
Caregiver Name Print: _____