Authorization for Disclosure of Protected Health Information

SANFORD HEALTH

Patient Name: _____ **Date of Birth**: _____
Full Address: _____
Phone Number: _____
Maiden/Previous Names _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility: _____
Address: _____
City, State, Zip: _____
Phone: _____

Release Information To:

Name/Facility: Sanford Health Leave Management Team
Address: 2200 E Benson Road
City, State, Zip: Sioux Falls SD 57104
Phone: 877-243-1372

Purpose of Release:

☐Continuing Medical Care ☐Work Comp ☑Disability Determination ☐ Personal
☐Insurance Claim ☐Application for Insurance ☐Other: _____

Delivery Method: Date information desired by: _____

Release Format (Check 1 of 3 options only):

1) ☑ Paper via ☐Mail **OR** ☐ Pick Up **OR** ☑ Fax *(as appropriate)* **Fax #: 605-312-9051**
2) ☐ USB ☐Mail **OR** ☐ Pick Up
3) ☐ Electronic via *My Sanford Chart* Patient Portal
☐Release to ALL My Sanford Chart Proxies

Information to be Released:

Service Dates: From: _____ To: _____ **OR** ☐ all future records until this authorization expires
NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____

☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe)*.

☐ Discharge Summary ☐ ER Records ☐ History & Physical ☐ Clinic Visit Notes
☐ Psychological Evals/Assmts ☐ EKG/Cardiology Reports ☐ Immunization Records ☐ Operative Reports
☐ Lab / Pathology Reports ☐ Radiology Images ☐ Radiology reports ☐ Entire Medical Record
☐ Billing Statements ☑ Other: All records pertaining to leave of absence request (*charge may apply*)
☐ Alcohol/Drug Treatment Records _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits

☐ **By checking this box, I agree that my signature will be the electronic representation of my signature**

Signature *(required)*	**Date Signed** (required)
Printed Name of Person Signing (If not patient):	