Authorization for Disclosure of Protected Health Information

Orange City Area Health System

Patient Identification	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City/State: _____ Zip Code: _____ Maiden/Previous Names/ Nickname: _____ SSN#_____
Provider (Who is releasing information?)	Provider/Facility Name: _____ Phone: _____ Ext:_____ Address: _____ Fax: _____ City/State: _____ Zip Code: _____
Disclose Information To: (Where is information to be sent?)	Name/Facility: *Orange City Area Health System* Address: *1000 Lincoln Circle SE* City/State: *Orange City, IA* Zip Code: *51041* Phone: *712-737-5248* Fax: *712-737-5280*
Information to be Disclosed	□ Clinic Progress Notes ____ Physician's ____ Nurse's ____ Other □ Hospital Progress Notes ____ Physician's ____ Nurse's ____ Other □ EKG/Cardiology Reports □ Radiology Reports □ ER Records □ History & Physical □ Discharge Summary □ Operative Report □ Immunization Record □ Treatment for Drug or Alcohol Dependency □ Radiology Images (specify date) □ Lab Data □ Pathology Report □ Psychiatric Evaluation □ Outpatient Information □ Consultation □ PT Notes □ All Records □ Other (Please Specify) _____
Service Dates	Time period from _____ to _____ Concerning: _____ (specific diagnosis or treatment, auto accident, etc.)
Purpose of Disclosure	□ Continuing Medical Care □ Consult/Second Opinion □ Out of town move □ Insurance Claim □ Legal □ Personal □ Other (Please Specify) _____
Expiration Date	This authorization will expire one year from the date of signature or on _____.
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.
Authorization	I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits. _____ _____ (Signature of patient/representative) (Signature Date) _____ _____ (Relationship to patient, if signed by representative) (Witness – optional) *Please supply proof of authority to act. For minors, proof only required if other than parent.

FOR OFFICE USE ONLY

- ❑ **To be mailed**
- ❑ **To be faxed- only fax if it is 20 pages or less. NO AUTOFAXES PLEASE.**

ROI Form Faxed/Mailed by:_____

Date:_____