

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: <u>Orange City Area Health System</u> Address: <u>1000 Lincoln Circle SE</u> City/State: <u>Orange City, IA</u> Zip Code: <u>51041</u> E-mail: <u>ochealthinformation@ochealthsystem.org</u>		
	Phone: 712-737-5248		Fax: 712-737-5280
Disclose Information To: (Where is information to be sent?)	Name/Facility: _____ Phone: _____ Address: _____ Fax: _____ City/State: _____ Zip Code: _____		
Information to be Disclosed	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Hospital Progress Notes <input type="checkbox"/> Physician's <input type="checkbox"/> Nurse's <input type="checkbox"/> Other </div> <div style="width: 33%;"> <input type="checkbox"/> EKG/Cardiology Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> ER Records <input type="checkbox"/> History & Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative Report <input type="checkbox"/> Immunization Record <input type="checkbox"/> Treatment for Drug or Alcohol Dependency <input type="checkbox"/> Lab Data <input type="checkbox"/> Radiology Images (specify dates) </div> <div style="width: 33%;"> <input type="checkbox"/> Pathology Report <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Outpatient Information <input type="checkbox"/> Consultation <input type="checkbox"/> PT Notes <input type="checkbox"/> All Records <input type="checkbox"/> Other (Please Specify) </div> </div> <input type="checkbox"/> Clinic Progress Notes <input type="checkbox"/> Physician's <input type="checkbox"/> Nurse's <input type="checkbox"/> Other		
Service Dates	Time period from _____ to _____ Concerning: _____ (specific diagnosis or treatment, auto accident, etc.)		
Purpose of Disclosure	<input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Other (Please Specify) <input type="checkbox"/> Consult/Second Opinion <input type="checkbox"/> Legal <input type="checkbox"/> Out of town move <input type="checkbox"/> Personal		
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.		

- ☐ To be mailed
- ☐ To be picked up
- ☐ To be faxed
- ☐ MyChart

Records released by _____ Date _____