# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
## SPIRIT LAKE HEALTH CENTER

**COMPLETE ALL SECTIONS, SIGN AND DATE:**

I. I, _____, hereby authorize the disclosure of information from my heath record.
**(Name of Patient)**

| II. The information is to be disclosed by: | And is to be provided to: |
|---|---|
| NAME OF FACILITY | NAME OF PERSON/ORGANIZATION/FACILITY |
| ADDRESS | ADDRESS |
| CITY/STATE | CITY/STATE |

III. The purpose or need for this disclosure is:
Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Insurance ☐
Personal Use ☐ Disability ☐ Other _____

IV. The information to be disclosed from my health record: (check appropriate box(es))
☐ Only information related to specify_____
☐ Only the period of events from _____ to _____
☐ Other (specify) (CHS, Billing, etc.) _____
☐ Entire Record

**IF YOU WOULD LIKE ANY OF THE FOLLOWING SENSITIVE INFORMATION DISCLOSED, CHECK THE APPROPRIATE BOX(ES) BELOW**:
☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)
☐ Psychotherapy Notes ONLY (**by checking this box, I am waiving any psychotherapy-patient privileges**)

V. I understand that I may revoke this authorization in writing, submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration event is stated.

_____
(Specify New Date)

I understand that the Spirit Lake Health Center will not condition treatment or eligibility for my care on my providing this authorization, except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rules (45 CFR Part 164).

| SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)* | DATE |
|---|---|
| SIGNATURE OF WITNESS *{If signature of patient is a thumbprint or mark)* | DATE |

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

ROI VERIFIED BY:
Know the Patient: ☐
Driver's License ID: ☐
Tribal Enrollment ID: ☐
Other: ☐

HIM Staff Initials _____ Date _____

| NAME *(Last, First, MI)* | RECORD NUMBER |
|---|---|
| ADDRESS | |
| CITY/STATE | DATE OF BIRTH |

INSTRUCTIONS FOR COMPLETING RELEASE OF INFORMATION FORM
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
SPIRIT LAKE HEALTH CENTER

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of the patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information.
   Also print the name of the person, facility and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc.
5. Section IV, check the appropriate box as applicable.
   a. Only information related to – specify diagnosis, injury, operations, special therapies, etc.
   b. Only the period of events from – specify date range e.g., Jan. 1, 2017 to Feb. 1, 2017.
   c. Other (specify) – e.g., CHS, Billing, Employee Health etc.
   d. Entire record – complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes.
   e. IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.
   f. Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATION FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATION PERTAINING TO PSYCHOTHERAPY NOTES.

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
6. Section V, if a different expiration date is desired, specify a new date.
7. Section V, Please sign (or mark) and date.
8. Name, Address and Date of Birth required in order to send/receive correct patient information.