

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
ACCESS TO PROTECTED HEALTH INFORMATION

Name of Patient: _____ Date of Birth: _____

I hereby authorize: _____
(Person or Organization)

to use and/or disclose information from dates: _____ to _____

to: _____
(Person or Organization to receive information) (Street) (City, State, Zip code)

EXPIRATION: This authorization will expire _____
(Insert date, event or "once purpose stated above is served")

INFORMATION TO BE USED AND/OR DISCLOSED:

- Checkboxes for Hospital admission summary, Hospital discharge summary, Operative reports, Laboratory reports, X-ray reports, X-ray films, Clinic Records, and Other* (please specify). Includes a note about marketing compensation.

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

PURPOSE OF THE USE AND/OR DISCLOSURE:

- Checkboxes for Further Treatment, Personal Records, Legal, Insurance Application, Transfer of Care, and Other.

Prohibition on Conditioning of Authorization: Oakes Community Hospital will not condition treatment on your signing this authorization, unless:

- Numbered list of conditions: # You are receiving research-related treatment, or # The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Revocation: I understand that I may revoke this authorization at any time by notifying Oakes Community Hospital in writing by sending a letter to the Privacy Official, Oakes Community Hospital, 1200 North 7th Street, Oakes, ND 58474-2502, (701-742-3291) or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Oakes Community Hospital took before it received my revocation letter. For example, Oakes Community Hospital cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Oakes Community Hospital's Notice of Privacy Practices.

Signature of individual or personal representative (relationship) _____ Date _____

