CHI Oakes Hospital
CLINIC
Imagine better health.℠

PATIENT INFORMATION

Authorization for Use or Disclosure of Protected Health Information

I, _____, born on _____,
(Print patient's, resident's or client's name) (Date of birth)

do hereby authorize _____ to use and/or disclose my
(Name of facility/provider)

individually identifiable health information as described below:

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City, State, Zip: _____

The following individually identifiable health information may be used and/or disclosed:
Check (✓) all that apply:

- ❑ Clinic Notes
- ❑ X-rays and Reports
- ❑ Lab Tests and Reports
- ❑ Immunization (shots) Received
- ❑ Other*:_____

* If authorization is for *marketing*, indicate if Oakes Community Hospital will receive compensation in exchange for the use and/or disclosure of the PHI.

❑ Yes ❑ No

Dates of treatment to be released: _____

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.

Reason or purpose for the use and/or disclosure of the information:

_____

I understand a fee may be charged for copies of my medical record.

If you are requesting copies of your own medical record, indicate here if you would prefer to receive them in an electronic format.

❑ Yes* ❑ No

*If yes, please specify format you are requesting: _____

PERMANENT CHART COPY

Prohibition on Conditioning of Authorization

Oakes Community Hospital will not condition treatment on your signing this authorization, unless:

- 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., physical education 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 re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration

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

Revocation

I understand that I may revoke this authorization at any time by notifying Oakes Community Hospital in writing by sending a letter to **Privacy Official, Oakes Community Hospital, 1200 North 7th Street, Oakes, ND 58474-2502** 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 had 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 Date

_____
Printed name of individual's personal representative, if applicable.

_____
Rationale for serving as personal representative to the individual (e.g., parent, legal guardian)

FOR INTERNAL PURPOSES ONLY

When Oakes Community Hospital is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel

Received by: _____ Date: _____

Was signed copy provided to the individual? ❑ Yes ❑ No
Approved for individual access? ❑ Yes ❑ No