## HIPAA Authorization for Release of Patient Information

Patient Name: ___________________________________ Maiden/Other Name: _________________________________________

DOB: _________________________________ Phone:____________________________

I authorize release of information from ____________________________________________________________________________
(Name and Address of Health Care Facility/Provider)

To be released to: ________________________________________________________ Fax: _______________________________
(Name of Individual, Health Care Facility/Provider, or Other Entity)

**Method of Delivery**

☐Fax (Unsecured)*- Only available if less than 50 pages ☐Mail ☐Pickup ☐Email (Secure) ☐ Email (Unsecure)

***If you choose to receive information via unsecured fax or email, St. Luke's Hospital cannot accept responsibility for the security of your records while in transit.**

**INFORMATION TO BE RELEASED:**

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE.**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR 164.524).
3) I may revoke this authorization at any time by notifying St. Luke's Medical Center and affiliates in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law providers the insurer with the right to consent a claim under the policy. St. Luke's Hospital and affiliates agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of Information to Be Disclosed

- ☐ Entire Medical Record
- ☐ Office Chart Notes
- ☐ Billing Statements
- ☐ Dental Records
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Consultation
- ☐ Discharge Summary
- ☐ Most Recent 5 Year History
- ☐ All Hospital Records
- ☐ Transcribed Hospital Reports
- ☐ History and Physical Exam
- ☐ Emergency and Urgent Care Records
- ☐ Medical Records for Continuity of Care
- ☐ Diagnostic Imaging Reports
- ☐ Emergency Room Reports
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other______________________ __________________________ __________________________ ________________

In addition, I authorize that this will include health information relating to (check if applicable):

- ☐ HIV/AIDS infection
- ☐ Drug/Alcohol abuse
- ☐ Genetic Testing
- ☐ Mental Health Record

_______________________________________________ _______________________________
Signature of Patient or Personal Representative Date

_______________________________________________ _______________________________
Print Name of Patient or Personal Representative Date

_______________________________________________ _______________________________
Witness Date

**702 1st Street SW - PO Box C**
**Crosby, ND 58730**
**701-965-6349**
**Fax: 701-965-6407**
**TYY: 1-800-366-6888**

*This institution is an equal opportunity provider and employer.*