Sioux Center Health
An Avera Partner

SX.ROI

HEALTH INFORMATION MANAGEMENT AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Medical Record#

Acct #.

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip_____ Phone: _____

Maiden/Previous Name/Nicknames: _____

Provider who is releasing information

Provider/Facility Name: _____ OR Sioux Center Health:

Address: _____ ☐ Medical Clinic

City/State/Zip_____ ☐ Hospital

Phone:_____ Fax: _____ ☐ Medical Clinic & Hospital

Disclosing Information to whom/ where

Receiver Name/Facility: _____

Address: _____ Phone:_____

City/State/Zip_____ Fax: _____

Information to be disclosed

☐ Clinic Notes
☐ Hospital Progress Notes
☐ EKG/Cardiology Reports
☐ Radiology Reports
☐ ER Notes
☐ History & Physical
☐ Discharge Summary
☐ Operative Report
☐ Immunization Record
☐ Treatment for Drug/Alcohol Dependency
☐ Lab Data
☐ Pathology Reports
☐ Psychiatric Evaluation
☐ Outpatient Information
☐ Consultation
☐ PT Notes
☐ Urgent Care Notes
☐ All Records
☐ Other (please specify)

Service Dates

Time period from: _____ to _____

Concerning (specific diagnosis or treatment, auto accident, etc.)_____

Form and Format

☐ Paper record ☐ Fax ☐ CD-ROM (compact disc)
☐ Electronically by e-mail (all emails will be encrypted)
Please provide email address: _____

Purpose of Disclosure

☐ Continuing Medical Care ☐ Consult/Second Opinion ☐ Moved out of Town
☐ Insurance Claim ☐ Legal ☐ Personal
☐ Other (please specify)_____

I specifically authorize the release of information relating to the following categories (check any category to be released)

☐ Substance Abuse ☐ Mental Health ☐ HIV related information

Authorization

I understand that I may revoke this authorization at any time by sending a written notice to Sioux Center Health, 1101 9th St SE, Sioux Center, IA 51250. I understand the revocation will not apply to information already released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date/event/condition_____ _____. If I fail to specify an expiration date/event/condition, this authorization shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

I understand authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CPR164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, relationship to patient Signature of Witness

☐ to be mailed Mailed by _____ on date _____
☐ to be picked up Given by _____ on date _____
☐ to be faxed/emailed Faxed/Emailed by _____ on date _____