McKenzie Health

AUTHORIZATION FOR USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

INSTRUCTIONS: Please submit this completed form to: McKenzie Health ATTN: Medical Records,
709 4th Ave. NE, Watford City, ND 58854, Telephone: (701) 444-8709, Fax: (701) 842-4503. Email: him@mchsnd.org

FORM MUST BE COMPLETED IN ITS ENTIRETY. INCOMPLETE FORM COULD DELAY RESPONSE.

Patient Name: (Last, First, Other/Alias)	DOB:	Phone #:
Address:	City	State/Zip:

I Authorize:
☐ McKenzie Health
☐ Other:____
____
Phone:____________________ Fax:___________________

Release To:
☐ Self (Patient) ☐ McKenzie Health ☐ Third Party**
____
____
Phone:_____________________ Fax:________________

Purpose of Disclosure:
☐ Transfer of Care ☐ Personal Records ☐ Legal ☐ Insurance ☐Other:Specify:___________________________________

Information to be released: ☐ Specific Date(s) From:__________________ To:________________
☐ Future Visits: (If this is checked, you will need to call Medical Records to make request to send records.)

☐ Entire Medical Record	☐ ER Record	☐ History & Physical
☐ Discharge Summary	☐ Pertinent Only (Provider notes & test results)	☐ Operative Reports
☐ Physical and/or Occupational Therapy	☐ Cardiac and/or Pulmonary Rehab	☐ Consultations
☐Lab/Pathology Reports	☐ Immunizations	☐ Billing Statement/Claim
☐Provider Clinic Record (Provider Names) ________________________________ ________________________________	Radiology: ☐ Entire Record ☐ Images ☐ Report Only	☐ Other:_________________________ _________________________________ _________________________________ _________________________________

Delivery Options: ☐ Secure (encrypted) Email (List):____
☐ Mail ☐ Pick-Up ☐ Fax

** If releasing to Third Party, I acknowledge that the released information may contain alcohol, drug abuse, HIV, and mental health information. It is my intent that information released is prohibited for any other purpose than that which is stated above.

I understand that:

1. I have a right to revoke this authorization at any time by giving notice to the office listed above. I understand the revocation will not apply to information that has already been released in response to this authorization.
2. This authorization will expire on:______________________(specify date or event), otherwise this authorization will expire twelve months after the date of signature.
3. Authorizing the disclosure of my health information is voluntary. My treatment may not be conditioned on signing this authorization.
4. I may inspect or copy the information to be used or disclosed as provided in CFR 164.524
5. Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
6. I may be charged at minimum $20.00, plus $.75/page depending on the specifics of this request.

I have read the above and authorize the disclosure of the protected health information as stated.	
Signature of Patient/Patient Representative	Date:
Print Name of Patient/Patient Representative	*Relationship or scope of your legal authority to act on the patient's behalf.

☐ Check if information has been released.

*Supporting documentation may be required.