Perham Health
SANFORD

Authorization for Disclosure of Protected Health Information

Patient Name:____Date of Birth:______________
Full Address:____
Phone Number:____
Maiden/Previous Names:____

Instructions: Fill out each section of the form in its entirely. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility:
____
Address:
____
City/State/Zip:
____
Phone:
____

Release Information To:

Name/Facility:
____
Address:
____
City/State/Zip:
____
Phone:
____

Purpose of Release:

☐Continuing Medical Care ☐Work Comp ☐Other:_______________________________
☐Insurance Claim ☐Disability Determination ___________________________________
☐Application for insurance ☐ Personal ___________________________________

Delivery Method: Date information desired by:_______________

Release Format (Check 1 of 3 options only):
1.☐Paper via ☐Mail **OR** ☐Pick Up **OR** ☐Fax (as appropriate) FAX#:______________________
2.☐USB ☐Mail **OR** ☐Pick UP
3.☐Electronic via My Sanford Chart Patient Portal ☐Release to **ALL** my Sanford Chart Proxies

Information to be Released:

Service Dates: From:___________ To:___________ **OR** ☐all future records until this authorization expires
NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:____
☐Abstract (history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe)

☐Discharge Summary ☐ER Records ☐History & Physical ☐Clinic visit notes
☐Psychological Evals/Assmts ☐EKG/Cardiology Reports ☐Immunization Records ☐Operative reports
☐Lab/Pathology Reports ☐Radiology Images ☐Radiology Reports ☐Entire Medical Record (charge may apply)
☐Billing Statements ☐Other____
☐Alcohol/Drug Treatment Records____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

________Do not release alcohol or drug treatment records protected under federal law

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature (required):	**Date Signed:**

Printed Name of Person Signing (If not the Patient):