NSHC Authorization to Use and Disclose Health Information

(Norton Sound Health Corporation to Release Information to Other Party)

Patient

Patient Name: _____ **Birth Date:** _____/_____/_____ **Ph. #:** _____/_____/_____

Address: _____ **Medical Record #** _____

From

I authorize Norton Sound Health Corporation (NSHC) to disclose Patient's health information as describe below

To

Health information is to be disclosed to and received and used by:
Fill in the name of the person or facility with an address, number & a fax number

Name/Facility or Self: _____ ***Phone Number:*** _____/_____/_____

Address: _____ ***Fax Number:*** _____/_____/_____

I Authorize, _____***, if I'm unable to pick up my medical records. (I.D required from both parties)***

***Select Format:** ☐ **Paper Form** ☐ **Secured Compact Disc (CD)**

Purpo

For the purpose(s) of: ☐ **At my request** ☐ **Other purposes (specify each purpose):** _____

Information to be Disclosed

Description or nature of information to be disclosed and includes information in any medium, including paper, electronic, and verbal information: (check all that apply)

- ☐ Discharge summaries
- ☐ History & physical exams
- ☐ Consultations
- ☐ Operative reports
- ☐ Physician progress notes
- ☐ Nursing notes
- ☐ Medication records
- ☐ Pathology reports
- ☐ Radiology & imaging reports
- ☐ Laboratory reports
- ☐ EKG Reports
- ☐ Emergency Dept. records
- ☐ Billing statements
- ☐ Clinic or office notes

Specially Protected Information about:
(must be checked to be disclosed):

- ☐ Mental health treatment
- ☐ Drug/alcohol abuse diagnosis, treatment, & referral
- ☐ HIV / AIDS Information
- ☐ Reproductive Health Care Information

☐ **Records for the following dates or treatment:** _____
(Specify the information you are requesting with the Months, Dates, and or Years)

☐ **ALL MEDICAL RECORDS:**_____
All health records from NSHC (Minimum Necessary for purposes of disclosure) (Excludes the above Specially Protected Information unless box(es) checked.)

Notices

1. There is the potential for information disclosed under this authorization to be re-disclosed by the recipient and no longer protected by federal or state privacy laws. But, if the information being disclosed under this authorization includes HIV/AIDS, mental health, and drug/alcohol abuse information, then federal or state law may prevent the recipient from re-disclosing this information.

2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations, or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.

3. I may revoke this authorization at any time by notifying, in writing, the Director of Health Information Management of NSHC; however, any such revocation will not apply to any disclosure or action already undertaken based on this authorization.

4. I understand that if the information is related to reproductive health care information that the use and disclosure is not for prohibited purposes. I understand this requirement applies to the request of reproductive health care information for any of the following; health oversight activities, Judicial and administrative proceedings, law enforcement purposes, and disclosures to coroners and medical examiners.

5. I will receive a copy of this authorization after it is signed. I may inspect or request copies of information disclosed by this authorization.

Dates

Unless revoked, this authorization is valid for the following time period:

Beginning date: ____/____/____ **Ending (expiration) date:**____/____/____

Signature

SIGNATURE: I have read this authorization; I have had an opportunity to ask questions; I understand this authorization; and I willingly am signing this authorization.

_____ ***Date:*** ____/____/____

Signature of Patient or legal/personal representative
If not signed by Patient, Authority to sign on behalf of Patient: _____

(Specify relationship to the Patient)