MONUMENT HEALTH

* E R O I *

Authorization for Disclosure / Release of Protected Health Information

Request #: _____

Medical Record #:_____

Complete all sections with arrows.

Patient's Legal Name: (PRINT) _____ **Date of Birth:** _____

Facility, individual, or group of individuals authorized to release information:

- ❑ Monument Health Assisted Living
- ❑ Monument Health Behavioral Health Center
- ❑ Monument Health Custer Hospital
- ❑ Monument Health Custer Care Center
- ❑ Monument Health Heart and Vascular Institute
- ❑ Monument Health Home+ Hospice
  Specify Facility: _____
- ❑ Monument Health John T. Vucurevich Cancer Care Institute
- ❑ Monument Health Lead-Deadwood Hospital
- ❑ Monument Health Medical Clinic
  Specify Facility: _____
- ❑ Monument Health Orthopedic and Specialty Hospital
- ❑ Monument Health Rapid City Hospital
- ❑ Monument Health Rehabilitation
  ❑ Center or ❑ Institute
- ❑ Monument Health Sleep Center
- ❑ Monument Health Spearfish Hospital
- ❑ Monument Health Sturgis Hospital
- ❑ Monument Health Sturgis Care Center
- ❑ Monument Health Surgery Center (SP)
- ❑ Monument Health Urgent Care
  Specify Facility:_____
- ❑ Same Day Surgery Center
- ❑ Other: _____

Information to be disclosed:

- ❑ Verbal Information Only *Specify:* _____
- ❑ **Behavioral Health Inpatient Reports* Must initial below**
- ❑ **Behavioral Health Outpatient Reports* Must initial below**
- ❑ Billing Information
- ❑ Cardiac Cath
- ❑ **Chemical Dependency Evaluation* Must initial below**
- ❑ Clinic Notes
- ❑ Complete Medical Record
- ❑ Completion Note
- ☒ Consultation Reports
- ❑ Dictated Reports
- ❑ Discharge Summary
- ❑ Electrocardiogram (EKG)
- ❑ ER Chart / Dictation
- ❑ Evaluation
- ❑ History and Physical
- ❑ Laboratory
- ❑ Long Term Care Records
- ❑ Medications
- ❑ **Neuropsychology Notes * Must initial below**
- ❑ Occupational Therapy Notes
- ❑ Operative Summary
- ❑ Pain Management Notes
- ❑ Pathology Report
- ❑ Patient Portal Code or Access**
- ❑ Patient Status and progress toward discharge
- ❑ Physical Therapy Notes
- ❑ Progress Notes
- ❑ **Psychotherapy Notes* Must initial below**
- ❑ Speech Therapy/Audiology Notes
- ❑ X-Ray/CT/Nuclear Medicine******
- ❑ Other:_____

Specify date of service: _____

Release these records to:

Name: _____

Address: _____

_____

Telephone #: _____ Fax #: _____

For the purpose of: ❑ Continuing Care ❑ Insurance ❑ Legal ❑ Personal Use Other: _____

Your initials below allow the designated facility to disclose information protected under federal law relative to drug and/or alcohol treatment, psychiatric care, or, diagnosis or information specific to HIV, AIDS, or Sickle Cell Anemia.

I understand this will include information related to: *(initial if applicable; must be initialed for disclosure of this information)*

*(initials)*_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human immunodeficiency Virus) infection

*(initials)*_____ Psychiatric Care

*(initials)*_____ Sickle Cell Anemia

*(initials)*_____ Treatment for alcohol and/or drug abuse

***Your initials above allow the designated facility to disclose information protected under federal law relative to drug/alcohol treatment, etc.**

****The parent or authorized representative and the minor age 12 years or greater will co-sign the authorization to allow shared Portal access of the minor.**

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Request #: _____

Medical Record #:_____

Patient's Legal Name: (PRINT)_____ **Date of Birth:** _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply 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, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or other benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Release of Information Technicians.

I authorize the release of information as specified above. I release the above designated facility and individuals from all legal responsibility or liability, which may arise from the release of this information.

Patient/Legal Representative Signature:_____ **Date:** _____ Time: _____

Specify Relationship if Not Patient and PRINT Name: _____

Authorization Witnessed by Name PRINT _____

Authorization Witnessed by Signature:_____ **Date:** _____ Time: _____

****Medical Imaging Services (Radiology) Disclaimer:** If you have received copies of computer digital images please be advised that this print of a computer digital image is provided exclusively as a courtesy for the patient, who is the subject of the image. **The image displayed on this document is for reference only.** If an image is needed for diagnostic purposes, have your doctor or allied health professional contact the Medical Imaging Department at Rapid City Monument Hospital.

For the recipient of this information:
If the information released contains drug and alcohol diagnosis or treatment information (as indicated above), the following applies: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Standard Fees: Reasonable charges may be applied in accordance with Monument Health's current fee schedule. You will be notified of applicable fees before your request is processed.

For Monument Health Clinics Only

The following is to be reviewed and signed by the patient.

After the physician reviews your outside records, you have the option of picking them up or allowing the clinic to dispose of them by shredding. If no indication is made, the outside records will be shredded.

- ❑ Yes, I will pick up my records after they have been reviewed.
- ❑ You have permission to shred the outside records after they have been reviewed and the physician.

Records not picked up 60 days after receipt will be shredded.

Signature: _____ Date:_____ Time: _____

To be completed by Monument Health Caregiver(s)

Photo ID Verified* .....Date: _____ Initials: _____

Charges Explained.....Date: _____ Initials: _____

Records Picked up.....Date: _____ Initials: _____

Records Sent .....Date: _____ Initials: _____

Records Faxed.....Date: _____ Initials: _____

Pick Up X-Ray Films .....Date: _____ Initials: _____

To be picked up on .....Date: _____ Initials: _____

Complete the Disclosure Tracking Log when required and retain in patient record.
* Policy COC-8217-118

Caregiver Name Print: _____