MONUMENT HEALTH

Authorization for Disclosure / Release Protected Health Information

Patient Name PRINT: _____ **Date of Birth:** _____

Full Address: _____

Maiden / Previous Name(s): _____

Email Address: _____ Phone Number: _____

Release Information **FROM:**

☐ **Monument Health and Rapid City Medical Center**
(Includes all Monument Health Locations)

_____
Department / Facility

☐ **Other** – *specify organization, facility, department, provider below*

_____
Name

_____
Street Address

_____
City

_____
State Zip Code

_____
Phone Fax

Release Information **TO:**

Specify organization, department or individual below:

_____
Name

_____
Street Address

_____
City

_____
State Zip Code

_____
Phone Fax

_____
Email

Purpose of Release:

☐ Continuing Medical ☐ Work Comp ☐ Disability ☐ Personal ☐ Insurance ☐ Legal ☐ Other: _____

Delivery Method: (Select One) **Date Information Needed By:**

☐ Verbal Communication Name / Relationship: _____ ☐ MyChart
☐ Secure Email *(will be sent to above email address unless otherwise specified)* ☐ CD *(electronic release)*
☐ Fax (continuation of care only) to fax # listed above ☐ Paper *(will be sent USPS mail unless picked up as noted)*
☐ Pick-up at a Monument Health or Rapid City Medical Center Location

Information to be Released:

Service Dates to be release: From: To: **AND** ☐ all future record until authorization expires
☐ Standard Packet *(history and physical, discharge summary, operative report, consults, clinic notes, test results, labs, ER notes, provider notes related to specific timeframe)* ☐ Cardiology Reports ☐ Clinic Visit Notes ☐ Complete Medical Record *(charges may apply)l* ☐ Consult Notes
☐ Discharge Summary ☐ ER Records ☐ History and Physical ☐ Immunizations ☐ Lab / Pathology Reports ☐ Operative Reports
☐ Radiology Images ☐ Radiology Reports ☐ Telephone Encounters ☐ Therapy Notes ☐ Alcohol / Drug Treatment Records
☐ Itemized Billing Statements ☐ Other: _____

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 part 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. **This authorization expires one year from the day of my signature unless I specify a different event, purpose or alternative expiration date if less than one year here:**

_____.

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: _____