



SOUTHWEST HEALTHCARE SERVICES

802 2nd ST NW
BOWMAN, NORTH DAKOTA 58623
HOSPITAL: 701-523-5555 FAX: 701-523-7104
CLINIC: 701-523-5555 FAX: 701-523-7126

Date needed by: _____

____ To Mail

____ To Pick Up

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Information	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City/State/Zip: _____ Maiden/Previous Name(s)/Nickname: _____ Social Security Number: _____
Provider <small>(who is releasing the information)</small>	Provider/Facility Name: _____ Address: _____ Phone: _____ City/State/Zip: _____
Disclose Information To <small>(where information is to be sent)</small>	Name/Facility: _____ Doctor/Specialist: _____ Address: _____ Phone: _____ City/State/Zip: _____ Fax: _____
Information To Be Disclosed <small>(information disclosed also includes information from the patient portal account if applicable)</small>	<input type="checkbox"/> Lab/EKG/Cardiology Reports <input type="checkbox"/> All Records <input type="checkbox"/> Other (specify below) <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Radiology Reports _____ <input type="checkbox"/> Immunization Records <input type="checkbox"/> Hospital Dictated Notes <input type="checkbox"/> Clinic Dictated Notes
Purpose of Disclosure <small>(please be specific)</small>	<input type="checkbox"/> Continued Medical Care <input type="checkbox"/> Consult/Second Opinion <input type="checkbox"/> Out of town move <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other (please specify) _____
Expiration Date	This authorization will expire <u>one year</u> from the date of signature or on: _____
Revocation	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 any written revocation to the health information management 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.
Authorization	<p>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. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential of an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and/or drug abuse.</p> <p>_____ Signature of patient/representative _____ Signature Date</p> <p>_____ (relationship to patient, if signed by representative) _____ Witness – optional</p>
Office Use Only	FOR OFFICE USE ONLY: Date: _____ Completed by: _____ <input type="checkbox"/> Mailed <input type="checkbox"/> Faxed <input type="checkbox"/> Picked Up Medical Record #: _____