Sioux Center Health
An Avera Partner

SX.ROI

HEALTH INFORMATION MANAGEMENT AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Medical Record#

Acct #.

Patient Information

Name: _____ Date of Birth: _____

Address: _____ SSN_____

City/State/Zip_____ Phone: _____

Maiden/Previous Name/Nicknames: _____

Provider who is releasing information

Provider/Facility Name: _____

Address: _____ Phone:_____

City/State/Zip_____ Fax: _____

Disclosing Information to whom/ where

Receiver Name/Facility: _____

Address: _____ Phone:_____

City/State/Zip_____ Fax: _____

Information to be disclosed

- ☐ Clinic Progress Notes
  - ☐ Physician's
  - ☐ Nurses'
  - ☐ Other
- ☐ Hospital Progress Notes
  - ☐ Physician's
  - ☐ Nurses'
  - ☐ Other
- ☐ Other (please specify)
- ☐ EKG/Cardiology Reports
- ☐ Radiology Reports
- ☐ ER Records
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Immunization Record
- ☐ Treatment for Drug/Alcohol Dependency
- ☐ Lab Data
- ☐ Pathology Reports
- ☐ Psychiatric Evaluation
- ☐ Outpatient Information
- ☐ Consultation
- ☐ PT Notes
- ☐ All Records

Service Dates

Time period from: _____ to _____

Concerning (specific diagnosis or treatment, auto accident, etc.)_____

Purpose of Disclosure

- ☐ Continuing Medical Care
- ☐ Insurance Claim
- ☐ ER Records
- ☐ Consult/Second Opinion
- ☐ Legal
- ☐ Other (please specify)_____
- ☐ Moved out of Town
- ☐ Personal

I specifically authorize Sioux Center Health to release information relating to the following categories (check any category to be released)

☐ **Substance Abuse** ☐ **Mental Health** ☐ **HIV related information**

Authorization

I understand that I may revoke this authorization at any time by sending a written notice to Sioux Center Health, 1101 9th St SE, Sioux Center, IA 51250. I understand the revocation will not apply to information already released in response to this authorization or 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/condition_____. If I fail to specify an expiration date/event/condition, this authorization shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

I understand authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CPR164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, relationship to patient Signature of Witness

- ☐ to be mailed — Mailed by _____ on date _____
- ☐ to be picked up — Given by _____ on date _____
- ☐ to be faxed — Faxed by _____ on date _____