AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

*Name_________________________ *Date of Birth______________ MR #_______________

I, hereby authorize CHI St. Francis Health to use and/or disclose my individually identifiable health information as described below:
I authorize the following person(s) or organization to receive the information:

____
Address____________________________________ Phone Number____________________
City, State, and Zip Code: ____

The following individually identifiable health information may be used and/or disclosed:
*Dates of treatment to be released:____

Check (√) all that apply:

__Discharge Summary	__X-ray Reports	__Lab Reports
__History and Physical Records	__Emergency Room Records	__Rehab Therapy Notes
__Operative Report	__Consultation Reports	__Care Plans
__Pathology Report	__Verbal Status Updates	__MDS

__Clinic Records**____
__Home Care Records**____
__Nursing Home Records**____
__Other*: ____

* If authorization is for *marketing*, indicate if CHI St. Francis Health will receive compensation in exchange for the use and/or disclosure of the PHI. ___ YES or ___ NO

** Specific records must be identified.

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/ mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:
*____

(Please read the information regarding this authorization on the backside of this page.)

<u>This Authorization is binding</u>: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the CHI St. Francis Health's Notice of Privacy Practices.

*____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

Printed name of individual's personal representative, if applicable: ____________________
Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):
____

* Must be completed to be valid authorization.

(Over)

Prohibition on Conditioning of Authorization: CHI St. Francis Health will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire one year from the date of signature.

Revocation: I understand that I may revoke this authorization at any time by notifying CHI St. Francis Health in writing by sending a letter to Health Information Management Department, CHI St. Francis Health, 2400 St. Francis Drive, Breckenridge, MN 56520, or completing the Revocation of Authorization form (#305-02b). I understand that if I revoke this authorization, it will not affect any actions that CHI St. Francis Health took before it received my revocation letter. For example, CHI St. Francis Health cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

FOR INTERNAL PURPOSES ONLY

When CHI St. Francis Health is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: ______________________________ Date: ____________________

Was a signed copy provided to the individual and acknowledged? YES NO