AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
ACCESS TO PROTECTED HEALTH INFORMATION

Name of Patient: _____ Date of Birth: _____

I hereby authorize: **CHI St. Joseph's Health, 600 Pleasant Avenue, Park Rapids, MN 56470**
(Person or Organization)
to use and/or disclose information from dates: _____ to _____

to: _____
(Person or Organization to receive information) (Street) (City, State, Zip code)

EXPIRATION: This authorization will expire _____.
(Insert date, event or "once purpose stated above is served")

INFORMATION TO BE USED AND/OR DISCLOSED:

☐ Hospital Admission Summary ☐ Hospital Discharge Summary ☐ Operative Reports
☐ Laboratory Reports ☐ X-Ray Reports ☐ X-Ray Films
☐ Other (please specify): _____
* If authorization is for *marketing,* indicate if CHI St. Joseph's Health will receive compensation in exchange for the use and/or disclosure of the PHI. _____ Yes or _____ No

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.

PURPOSE OF THE USE AND/OR DISCLOSURE:
θ Further Treatment θ Insurance Application θ Legal θ Personal Records θ Other _____

Prohibition on Conditioning of Authorization: CHI St. Joseph's Health Services 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 redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Revocation: I understand that I may revoke this authorization at any time by notifying CHI St. Joseph's Health in writing by sending a letter to the **Health Information Management Dept.**, CHI St. Joseph's Health, 600 Pleasant Avenue, Park Rapids, MN 56470 Phone: 218-616-3039 or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that CHI St. Joseph's Health took before it received my revocation letter. For example, CHI St. Joseph's Health cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

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

_____ _____
Signature of individual or personal representative (relationship) **Date**
PERMANENT HIM COPY