

(Place Patient Identification Label Here)  
Do Not Place Label Over Hole Punches



Complete this form in black or dark blue ink *only*.



RELEASE X UNI-0005

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

### PLEASE FILL OUT COMPLETELY

#### 1. Patient Information

Legal Name of Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

#### 2. I authorize Benefis Hospitals or organization: to disclose my medical information to the following:

Individual's or Organization's Name \_\_\_\_\_

Individual's or Organization's Address \_\_\_\_\_

Individual's or Organization's Fax Number \_\_\_\_\_

Disclose information to me via:  Mail  Fax  Electronic Media (e.g. USB Drive, Email)  Self

Verbal to \_\_\_\_\_  Phone \_\_\_\_\_

#### 3. Description of information to be disclosed:

Date(s) of Service \_\_\_\_\_

The information I wish for Benefis to disclose: \_\_\_\_\_ Demographics for Social Security

\_\_\_\_\_ Physician Reports \_\_\_\_\_ Nursing Documentation \_\_\_\_\_ Billing Information

\_\_\_\_\_ Diagnostic Reports (X-rays, Lab, Other Testing) \_\_\_\_\_ Radiology (X-ray) Films

\_\_\_\_\_ Other (specify) \_\_\_\_\_

#### 4. I would like the following sensitive information disclosed (Check those that apply.)

\_\_\_\_\_ Alcohol/ Drug Abuse Treatment/ Referral \_\_\_\_\_ Mental Health (Other than Psychotherapy Notes)

\_\_\_\_\_ Sexually Transmitted Diseases \_\_\_\_\_ Genetic Testing

\_\_\_\_\_ HIV/Aids Testing & Treatment \_\_\_\_\_ Sexual & Reproductive Health

#### 5. The purpose of the disclosure is:

\_\_\_\_\_ To obtain Insurance Benefits \_\_\_\_\_ Other \_\_\_\_\_ Lay Caregiver \_\_\_\_\_ Social Security

\_\_\_\_\_ For Legal Reasons (please specify purpose) \_\_\_\_\_

6. This authorization will expire on this date or event: \_\_\_\_\_ If no date or event is specified, this authorization will expire 12 months from date signed. Authorization is for the information requested above and does not pertain to future dates of service.

7. See reverse for additional information regarding this authorization.

#### 8. Signature

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Legal Representative Printed Name

#### 9. Identification of requester (for Benefis Hospitals use)

\_\_\_\_\_ Government-issued Picture ID \_\_\_\_\_ Signature verified \_\_\_\_\_ Requester known to me \_\_\_\_\_ Government badge

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### 10. Revocation of Authorization

I understand that I have the right to revoke this authorization at any time in writing. My revocation does not apply to actions that Benefis Hospitals has already taken in reliance on my valid authorization prior to a revocation; nor does it apply to the disclosure to an insurance company if it is a condition of obtaining insurance coverage.

To revoke this authorization, I must submit the revocation in writing to the Benefis Hospitals Medical Records Department.

### 11. Refusal to Sign this Authorization

I understand that I do not have to sign this authorization as a condition of receiving treatment from Benefis Hospitals, except under the following circumstances:

- a) If my treatment is research-related, it may be conditional upon receipt of an authorization to use or disclose my medical information as necessary for the research.
- b) If my treatment is for the purpose of creating information for disclosure to a third party, the provision of the services may be conditional upon my signing an authorization.

### 12. Possible Rediscovery

I understand that the information that is disclosed in accordance with this authorization is no longer under the control of Benefis Hospitals and may be further disclosed by the receiving party and that it may no longer be protected by federal privacy rules.