(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 ______________ Social Security Number ______________________________

Address ______________________________ phone number ______________

Would you like to sign up for the patient portal? ☐ Yes ☐ No

If yes, please provide email address ______________________

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, CD)

☐ Verbal to ______________________________

3. Description of information to be disclosed:

Date(s) of service ______________________________

The information I wish for Benefits to disclose:

__________ Physician reports __________ Nursing documentation __________ Billing information

__________ Diagnostic reports (X-rays, lab, other testing) __________ Radiology (X-ray) films

__________ Other (specify) ______________________________

I further understand the information I am authorizing to be disclosed includes the following types of records. (Check those that apply.)

__________ Alcohol and/or drug treatment records __________ Psychiatric records

__________ HIV/AIDS results/records

4. The purpose of the disclosure is:

__________ To obtain insurance benefits __________ Other ______________ Lay caregiver

__________ For legal reasons (please specify purpose) ______________________________

5. 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.

6. See reverse for additional information regarding this authorization.

7. Signature

______________________ ________ ________ ______________________

Patient/Legal Representative Signature Date Time Patient/Legal Representative Printed Name

8. **Identification of requester (for Benefis Hospitals use)**

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

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9. 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.

10. 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 search-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.

11. Possible redisclosure

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.