



NSHC Authorization to Use and Disclose Health Information

(Norton Sound Health Corporation to Release Information to Other Party)

Patient	Patient Name: _____ Birth Date: ____/____/____ Ph. #: ____/____/____ Address: _____ Medical Record # _____														
From	<i>I authorize Norton Sound Health Corporation (NSHC) to disclose Patient's health information as describe below</i>														
To	Health information is to be disclosed to and received and used by: Fill in the name of the person or facility with an address, number & a fax number Name/Facility or Self: _____ Phone Number: ____/____/____ Address: _____ Fax Number: ____/____/____ <i>I Authorize, _____, if I'm unable to pick up my medical records. (I.D required from both parties)</i> *Select Format: ☐ Paper Form ☐ Secured Compact Disc (CD)														
Purpose	For the purpose(s) of: ☐ At my request ☐ Other purposes (specify each purpose): _____														
Information to be Disclosed	Description or nature of information to be disclosed and includes information in any medium, including paper, electronic, and verbal information: (check all that apply) <table border="0"><tr><td>☐ Discharge summaries</td><td>☐ Pathology reports</td></tr><tr><td>☐ History & physical exams</td><td>☐ Radiology & imaging reports</td></tr><tr><td>☐ Consultations</td><td>☐ Laboratory reports</td></tr><tr><td>☐ Operative reports</td><td>☐ EKG Reports</td></tr><tr><td>☐ Physician progress notes</td><td>☐ Emergency Dept. records</td></tr><tr><td>☐ Nursing notes</td><td>☐ Billing statements</td></tr><tr><td>☐ Medication records</td><td>☐ Clinic or office notes</td></tr></table> Specially Protected Information about: (must be checked to be disclosed): ☐ Mental health treatment ☐ Drug/alcohol abuse diagnosis, treatment, & referral ☐ HIV / AIDS Information ☐ Records for the following dates or treatment: _____ (Specify the information you are requesting with the Months, Dates, and or Years) ☐ ALL MEDICAL RECORDS: _____ All health records from NSHC (Minimum Necessary for purposes of disclosure) (<u>Excludes</u> the above Specially Protected Information unless box(es) checked.)	☐ Discharge summaries	☐ Pathology reports	☐ History & physical exams	☐ Radiology & imaging reports	☐ Consultations	☐ Laboratory reports	☐ Operative reports	☐ EKG Reports	☐ Physician progress notes	☐ Emergency Dept. records	☐ Nursing notes	☐ Billing statements	☐ Medication records	☐ Clinic or office notes
☐ Discharge summaries	☐ Pathology reports														
☐ History & physical exams	☐ Radiology & imaging reports														
☐ Consultations	☐ Laboratory reports														
☐ Operative reports	☐ EKG Reports														
☐ Physician progress notes	☐ Emergency Dept. records														
☐ Nursing notes	☐ Billing statements														
☐ Medication records	☐ Clinic or office notes														
Notices	1. There is the potential for information disclosed under this authorization to be re-disclosed by the recipient and no longer protected by federal or state privacy laws. But, if the information being disclosed under this authorization includes HIV/AIDS, mental health, and drug/alcohol abuse information, then federal or state law may prevent the recipient from re-disclosing this information. 2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations, or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else. 3. I may revoke this authorization at any time by notifying, in writing, the Director of Health Information Management of NSHC; however, any such revocation will not apply to any disclosure or action already undertaken based on this authorization. 4. I will receive a copy of this authorization after it is signed. I may inspect or request copies of information disclosed by this authorization.														
Dates	Unless revoked, this authorization is valid for the following time period: Beginning date: ____/____/____ Ending (expiration) date: ____/____/____														
Signature	SIGNATURE: I have read this authorization; I have had an opportunity to ask questions; I understand this authorization; and I willingly am signing this authorization. _____ Signature of Patient or legal/personal representative If not signed by Patient, Authority to sign on behalf of Patient: _____ (Specify relationship to the Patient)														