Osceola
REGIONAL HEALTH CENTER
AN AVERA PARTNER
600 Ninth Ave. N.
P.O. Box 258
Sibley, IA 51249-0258
712-754-2574

ROI

Authorization - Release Of Medical Records Information

Patient Identification	Patient name: _____ Date of birth: _____ Address: _____ City/state/zip: _____ Social Security Number (last 4 digits): _____ Phone: _____
Provider (Who is releasing information?)	The following individual or organization is authorized to make the disclosure: Provider name: _____ Address: _____ City/state/zip: _____ Phone: _____ Fax: _____
Disclose Information to (Where is information to be sent?)	Name/site: _____ Address: _____ City/state/zip: _____ Phone: _____ Fax: _____
Information to be Disclosed	❑ Standard chart copy (Includes Demographic Face Sheet, Physician Dictated Reports, All Test Results) ❑ X-ray and imaging reports ❑ Entire record (charges may apply) ❑ Other _____
Service Dates	Dates of service from (date) _____ to (date) _____
Form and Format	❑ Paper (pickup or mail) ❑ Fax ❑ Flash Drive ❑ CD-ROM (compact disc) ❑ E-mail (please provide address below) E-mail address: _____ All medical records requested in electronic format will be encrypted unless specifically requested otherwise by the patient. Sending medical records unencrypted has risks including the individual's PHI could be read or otherwise accessed by a third party. File size may limit ability to send by e-mail. **If you want your records sent unencrypted please initial here: _____**
Substance Abuse Documentation	❑ Check this box ONLY if you permit substance abuse records to be released. Requestor, take note: **42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE RECORDS**
Purpose of Disclosure	❑ Continued healthcare ❑ Completion/payment ❑ Personal ❑ Other _____
Expiration Date	Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.
Revocation	I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to: • Information already released in response to this authorization • My insurance company when the law provides my insurer with the right to contest a claim under my policy.
Authorization	I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the Osceola Regional Health Center Privacy Officer at 712-754-2574. _____ _____ Signature of Patient or Legal Representative Date _____ _____ If Signed by Legal Representative, Relationship to Patient Signature of Witness Date: _____ Information sent: _____