CHI St. Gabriel's Health

Imagine better health.℠

- St. Gabriel's Hospital
- Family Medical Center
- Little Falls Orthopedics
- CHI Health at Home
- St. Camillus Place
- CHI Albany Area Health

Authorization for Use or Disclosure of Protected Health Information

I, _____ , Medical Record # _____ DOB _____,
(*Print name of individual patient, resident or client)* hereby authorize CHI St. Gabriel's Health *(St. Gabriel's Hospital, Family Medical Center, Little Falls Orthopedics, Health at Home, etc.)* to use and/or disclose my individually identifiable health information as described below:

Records From:

_____

Address: _____

City, State, Zip: _____

Records To:

_____

Address_____

City, State, Zip:_____

The following individually identifiable health information may be used and/or disclosed:
Please check (✔) all that apply:

___ Discharge Summary
___ Face sheets with Final Diagnosis
___ Consultation Reports
___ Outpatient Clinic Notes
___ History and Physical Records
___ Radiology _____
___ Laboratory Results
___ Emergency Room Records
___ Immunization (shot) Record
___ Other: _____
___ Inpatient Records
___ Abstracts
___ Physical Therapy Notes
___ Procedures

Marketing: If authorization is for marketing, indicate if CHI St. Gabriel's Health will receive compensation in exchange for the use and/or disclosure of the PHI. ___ YES or ___ NO

Dates of treatment to be released: _____

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.

Reason or purpose for the use and/or disclosure of the information:

_____

I understand a fee may be charged for copies of my medical record.

If you are requesting copies of your own medical record, indicate here if would prefer to receive them in an electronic format. ___ YES or ___ NO

If YES, please specify format you are requesting _____

Prohibition on Conditioning of Authorization

CHI St. Gabriel's Health 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., physical education 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 re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration

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

Revocation

I understand that I may revoke this authorization at any time by notifying CHI St. Gabriel's Health in writing by sending a letter to Medical Records, CHI St. Gabriel's Health, 815 2nd Street SE, Little Falls MN 56345 or completing the Revocation of Authorization Form. I understand that if I revoke this authorization, it will not affect any actions that CHI St. Gabriel's Health took before it received my revocation letter. For example, CHI St. Gabriel'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. Gabriel's Health Notice of Privacy Practices.

_____ _____
Signature of Individual or Personal Representative **Date**

Printed name of individual's personal representative, if applicable:

_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

_____

FOR INTERNAL PURPOSES ONLY

When CHI St. Gabriel's Health is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel

Received by: _____ Date: _____

Was a signed copy provided to the individual? ___ YES ___ NO

Approved for individual access? ___ YES ___ NO