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

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

Benefis HOSPITALS

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

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) _____

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 (3 day wait)

_____ HIV/AIDS Results/Records

4. The purpose of the disclosure is:

_____ To obtain Insurance Benefits _____ Other _____ Lay Caregiver _____Social Security

_____ For Legal Reasons (please specify purpose) _____

5. See reverse for additional information regarding this authorization.

6. Signature

_____ _____ _____

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

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

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

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8. 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.

9. 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.

10. 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.