AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________ Maiden/Other Name: ______________

Chart Number: ______________________ Birthdate: ______________

I hereby authorize: ____
NAME OF HEALTHCARE PROVIDER

____

to release my records to: ______________ To: ExamOne
800 NW Chipman Rd. / Suite 5900
POBox 2340
Lee's Summit, MO 64063-1149
Toll Free 888-521-2004 (FAX: 800-997-2771)

The disclosure is being made for the following purpose(s)

- ☐ Diagnosis & Treatment
- ☐ Insurance/Billing
- ☐ Personal
- ☐ Legal
- ☐ Other: ______________

I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

Information to Be Released:	Date of Service:	Information to Be Released:	Date of Service:
☐ Clinic Notes		☐ Radiology Films	
☐ Discharge Summaries		☐ OB/GYN	
☐ History & Physical		☐ Pediatric	
☐ Report of Operations		☐ Immunizations	
☐ Consultations		☐ Oncology	
☐ Pathology Reports		☐ Physical Medicine	
☐ Laboratory Reports		☐ Cardiology	
☐ Radiology Reports		☐ Other: ______	

Authorization of Release of the Indicated Sensitive Records (*requires patient's initials*):

	Patient's Initials:
☐ HIV or AIDS	
☐ Chemical Dependency	

I release the above-named healthcare provider from all legal responsibility and/or liability that may arise from the release of the records I have specified.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except as permitted by law.

I understand that I may revoke this authorization in writing at any time to the hospital Privacy Officer except to the extent that action has been taken in reliance on this authorization or if the authorization was obtained as a condition of obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy or the policy itself.

This authorization will remain in effect until: ______________ (date). If no date is indicated, authorization will remain in effect for one year from the signature date, and will automatically expire without my revocation. I direct that a photocopy or fax copy of this authorization be granted the same authority as the original.

______________________________ ______________________
Signature of Patient or Representative Date

______________________________ ______________________
Name of Personal Representative (if applicable) Relationship to the patient and representative's authority to act for the patient

____
Printed Name of Dakota Clinic Representative Taking Request

Dakota Clinic Ltd., HIM.318 (F) 1
Revised 11-10-03