BARAGA COUNTY MEMORIAL HOSPITAL

Authorization for the Use and Disclosure of Individually Identifiable Health Information

Patient Name:	Medical Record Number:	Date of Birth:

1. I authorize the use or disclosure of the above named individual's protected health information as described below.
2. Individual/organization authorized to make the disclosure:
3. The information described below may be used by or disclosed to the following individuals or organizations:
   Name: Address:
   Name: Address:
4. Information to be used or disclosed. **Check** the appropriate boxes and include other information where indicated.

☐	Medical List	☐	Most recent history and physical	☐ Most recent discharge summary
☐	Laboratory Results	Date(s):	Type of Test:	
☐	X-ray & Imaging Reports	Date(s):	Type of Test:	
☐	Other (Please describe):			
☐	Films	☐	Obtain from Radiology department	

The films are the property of the BCMH Radiology Department, and they are released on loan for the express purpose of having another physician review them for medical purposes.

5. This information for which I am authorizing disclosure will be used for the following. ***(ALL PURPOSES MUST BE LISTED AND DESCRIBED.)***
6. I understand that the information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
7. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment.
8. I understand that once information is disclosed, it may be disclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.
9. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. The revocation will not be valid if BCMH has taken action in reliance on this authorization; or if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
10. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.
11. This authorization expires on/upon (Insert applicable date or event):

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient or authority to act for the patient

MEDICAL RECORD SENT VIA: (Check appropriate box.)

☐	Mail	☐	Electronic via CPSI	☐	Fax #	☐ Hand released to:

_____ _____
Signature of employee releasing record Date

The above signature is that of the patient and/or patient's s representative.
BCMH has verified the identify of (***name of patient and/or patient's representative***)**:**
Identification was obtained by means of the following verification. **Check** the appropriate boxes.

☐	Driver License	☐	Photo ID	☐	Birth Certificate	☐ Other:

In representative's capacity of (***note relationship to patient),*** he/she is authorized to act on behalf of the patient.

Distribution of copies: *Original to provider Copy to patient Copy to accompany use or disclosure* *HIPAA-3a*