Authorization for Disclosure of Protected Health Information

SANFORD HEALTH PLAN

Member Name:_____ Date of Birth:_____

Full Address:_____

Maiden/Previous Name:_____

Email Address:_____ Phone Number:_____

Release Information **FROM:**

☐ **Sanford Health Plan**

☐ **Other** - *specify organization, facility, provider below:*

Name

Street Address

City

State Zip Code

Phone Fax

Release Information **TO:**

Specify organization, department or individual below:

Name

Street Address

City

State Zip Code

Phone Fax

Email

Purpose of Release:

☐ Continuing medical care ☐ Personal

☐ Insurance/eligibility and benefits ☐ Legal ☐ Other:_____

Delivery Method: (Select One) **Date Information Needed by:**

☐ Secure Email (will be sent to above email address unless otherwise specified)

☐ Fax to fax # listed above

☐ Paper (will be sent via USPS mail)

Information to be Released:

Service Dates to be released: From: To:

☐ Eligibility/enrollment records ☐ Prior authorization records

☐ Case/medical management records ☐ Claims adjudication records

☐ Explanation of benefits

☐ Other (describe the specific information):_____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____Do **not** release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:**_____

Signature:_____ **Date:**_____ **Time:**_____

Relationship of Person Signing (If not member):_____

Return completed form to Sanford Health Plan: PO Box 91110 Sioux Falls, SD 57109 (800) 752-5863 Fax: (605) 328-6811