Instructions for Universal Disclosure of Health Information Form

PO Box 91110
Sioux Falls, SD 57109
(800) 752-5863
Fax: (605) 328-6811

SANFORD HEALTH PLAN

Your health information is considered private per the Health Insurance Portability and Accountability Act (HIPAA). To release your information to anyone, the enclosed form must be completed and returned.

Please read this entire page before completing and signing this form.
If you have any questions about the release of your health information or this form, please call the number on the back of your ID card. When complete, please return to us at PO Box 91110 Sioux Falls, SD 57109-1110 or fax to (605) 328-6811.

Instructions for each section of the form are below. Please print clearly; an incomplete form may be returned for more information.

- Sections 1, 2, 3, 8, 10 and 11 must be completed.
- Complete sections 4, 5, 6 and/or 7 to authorize what information should be released and how we should release it. If only section(s) 6 and/or 7 are completed, only **WRITTEN** information will be released.
- To release ALL information in any format, complete all sections.

1 Complete all patient/member information in this section to help Sanford Health Plan identify your health information to make sure only your information is released. If a suffix is used, (Sr., Jr., III), provide this as well.

2 Indicate if you are allowing Sanford Health Plan to provide and/or discuss your health information or if you are asking a company to release your information.

3 Indicate with which company/person(s) we can provide and/or discuss your health information with.

4 To allow a person to verbally discuss your health information with Sanford Health Plan, initial this section.

5 To allow a person over age of 18 to discuss your health information electronically (secure email or secure fax), initial this section. To allow others to view information in your secure member portal, go to **sanfordhealthplan.com/memberlogin** to provide access to others.

6 Specify what health information you want to release. If you want only a specific date range or certain sections of your health information released, please indicate in this section.

Please note: If you choose to release all health information, this may include mental health evaluation and treatment notes, concerns about drug and/or alcohol use, chemical dependency treatment, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

7 To include chemical dependency information in your release, you must initial this section.

To include psychotherapy information in your release, you must initial this section.

If you live in Minnesota, you must complete a separate Universal Form for Disclosure of Health Information for psychotherapy notes to be released.

8 Please indicate why you want to release your health information.

9 Read this section carefully. It contains specific information about stopping your request, re-disclosure of your health information and information about your rights.

10 Indicate when this authorization will expire.

11 Please sign and date the form. If you are a legally authorized representative of the patient/member, please complete the last 2 lines in this section. We may ask you to verify you are the patient or the patient's legally authorized representative.

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1 Patient/Member Information

First Name _____ Last Name _____ Date of Birth ___/___/___

Home Address _____ City _____ State ____ Zip _____

2 I am requesting my health information be released from:

☐ Sanford Health Plan

OR

Company or person(s) name _____

3 I am requesting my health information be provided to or discussed with:

Company or person(s) name _____

Address _____City _____ State ____ Zip _____

Phone Number _____ Fax _____

4 To provide authorization for the party in section 3 to **verbally** discuss your health information, please initial here: _____

5 To provide authorization for the party in section 3 to disclose your **electronic** health information, please initial here: _____.

6 Please indicate the date(s) and what information you are authorizing for release:

☐ All health information (see instructions to review what is included)

☐ Specific dates/years of treatment: _____

OR

To only release specific sections of your health information, indicate categories to be released:

☐ History and physical	☐ Surgical report	☐ Emergency room reports
☐ Progress notes	☐ Laboratory report	☐ Autopsy
☐ Discharge summary	☐ Pathology report	☐ Radiology reports/image(s)
☐ Care plan	☐ Medications	

☐ Other information or instructions _____

7 A special consent to release the following written information is required, even if you indicated above to release all health information.

Chemical dependency program information that addresses treatment related to alcohol or drug addiction and receives federal funding. This type of health information is different from notes about a conversation with a provider about alcohol or drug use. Initial here to release information: _____

Psychotherapy notes (Kept by your psychiatrist, psychologist or other mental health professional.)
Initial here to release this information: _____

Continued on reverse

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Patient/Member Name: _____

8 Indicate why you want this information released.

☐ Patient/Member's request ☐ Legal

☐ Review patient's current care ☐ Insurance application

☐ Treatment/continued care ☐ Payment

☐ Marketing purposes (payment or compensation involved? ☐ No ☐ Yes, amount _____)

☐ Other (please explain) _____

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9 I understand by signing this form, I am requesting the health information specified be released to the company and/or person named in section 3.

I understand I may stop this consent at any time by writing to company and/or person in section 2. If the party in section 2 has already released health information based on my consent, my request to stop will not apply to the health information that has already been released.

I understand when written health information specified in sections 6 and/or 7 is sent to the company/person(s) named in section 3, and if the company and/or person who receives your health information is not a health care provider or health plan covered by federal privacy laws, the information may no longer be protected by federal or state privacy laws.

I understand that this authorization is voluntary and I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

If understand that if I choose not to sign this form and the organization named in section 3 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

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10 This consent will end when indicated below or when the patient/member in section 1 reaches age 18:

☐ No expiration date ☐ One year from the date the form is signed

☐ On the following date: ___/___/___ ☐ When the following event occurs: _____

☐ When insurance coverage ends ☐ When I send notification

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11 I have read and understand the above information. My signature authorizes the disclosure of the information described.

_____

Patient/member signature Date

_____

OR legally authorized representative's signature Date

_____

Representative's relationship to patient/member Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Compliant with Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8.