SONS OF NORWAY

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

• This form complies with the HIPAA Privacy Rule •

PATIENT INFORMATION

(please print)

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

I hereby authorize: _____

name of physician's office/medical practice disclosing information

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip/Postal Code: _____

Information or types of information to be disclosed: All Medical Records, EKG Tracings and Test/Lab Results From the Past Five Years

Specify dates (or date ranges) if applicable: _____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation may be in writing and addressed to the privacy officer at Sons of Norway, 1455 West Lake Street, Minneapolis, MN 55408 or I may call 1-800-945-8851. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or the following date: _____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drugs and alcohol abuse, mental illness, Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted disease, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; **DO NOT RELEASE** _____

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Description of Representative's Authority (witness signature required) Signature of Witness