Horizon Health - Medical Records
PO Box 99
Howard, SD 57349
Email: PatientRecords@horizonhealthcare.org
P: 605.772.4950 **F:** 866.423.6811

AUTHORIZATION TO USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Any incomplete forms will be considered invalid and will not be processed to maintain full compliance with HIPAA (45 CFR 164.508).

Patient's Full Legal Name _____

Maiden Name/Other Name(s) Used _____ Date of Birth _____

Address _____ City/State/Zip _____

Phone _____ Email Address _____

WHO WILL SHARE PROTECTED HEALTH INFORMATION?	WHO WILL RECEIVE PROTECTED HEALTH INFORMATION?
Name/Organization _____	Name/Organization Horizon Health
Address _____	Address PO Box 99
City/State/Zip _____	City/State/Zip Howard, SD 57349
Phone _____ Fax _____	Phone 605-772-4950 Fax 866-423-6811
Email _____	Email PatientRecords@horizonhealthcare.org

WHY ARE WE SHARING THIS?

☐ Personal Use ☐ Transfer of Care ☐ Attorney ☐ Employment
☐ Continuing Medical Care/Referral ☐ Billing or Claims ☐ School ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED?

☐ Office/Progress Notes ☐ Imaging Reports ☐ Medication List ☐ Dental Records
☐ History & Physical ☐ EKG/Cardiology Reports ☐ Immunization Records ☐ Mental Health Records
☐ Lab Reports ☐ Diagnostic Test Reports ☐ HIV/AIDS Records ☐ Billing Records
☐ Other _____

Only medical records created by Horizon Health will be released unless otherwise requested.

DATES OF TREATMENT:_____ *If left blank, we will share records from the **last two (2) years**.*

HOW SHOULD WE RELEASE THE RECORDS?

☐ Email (Encrypted) _____ ☐ Mail (Paper) ☐ Pick up (Paper)
☐ Email (Unencrypted) _____ ☐ Fax

Unencrypted email may carry privacy risks because email is not always secure. By selecting unencrypted email, you accept this risk and confirm the email address provided is correct.

PATIENT RIGHTS AND AUTHORIZATION

- I understand that signing this authorization is voluntary, and refusing to sign will not affect my treatment, payment, enrollment, or eligibility for benefits, except where permitted by law.
- Substance use disorder records protected under 42 CFR Part 2 may not be disclosed or redisclosed without your written authorization unless otherwise permitted or required by law.
- Unless revoked earlier, this authorization will expire on the date listed _____or one (1) year from the date signed. I may revoke this authorization at any time by submitting a written request to the Privacy Officer at compliance@horizonhealthcare.org; however, the revocation will not apply to information already released in reliance on this authorization.
- Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that I have the right to receive a copy of this signed authorization.
- By signing below, I authorize the use and disclosure of the health information described in this authorization. I understand and acknowledge that the information requested may include dental, medical, and clinical records; behavioral and mental health records; substance use disorder treatment records; HIV/AIDS-related information; genetic testing results; and sexually transmitted infection information. I further understand that psychotherapy notes are not included in this authorization and require a separate authorization form.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

_____ _____
Signature of Patient/ Guardian / Legal Representative Date

_____
Printed Name of Patient/Guardian/Legal Representative

Authority to act on behalf of the Patient *(Documentation required upon request)*
☐ Parent ☐ Legal guardian ☐ Health care power of attorney/agent ☐ Other _____

STAFF USE ONLY

☐ Faxed to Other Facility ☐ For chart only ☐ Identification Verified ☐ Records Released to Patient for In-Clinic Pick Up
Employee Name _____ Date _____ **Return to the Medical Records Dept. when completed.**