Custer Health
For a healthier way of life.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form authorizes Custer Health to use and disclose your protected health information. Please complete this form in its entirety. Contact Custer Health's Privacy Officer at 701-667-3370 if you have questions in relation to this authorization.

Name:					Date of Birth:		
Street Address:		City:		State:		Zip Code:	
Telephone Number:							
Date Request:							

I _____ authorize Custer Health staff to (check all that apply):

☐ Use the following protected health information, and/or

☐ Disclose the following protected health information to:

Description of the information to be used or disclosed (Describe the specific protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.).

This protected health information is being used or disclosed for the following purposes:

This authorization is in effect until (please choose one):

☐ Date _____ (Up to 5 years)

☐ End of the research study

☐ No end date

I understand that I have the right to revoke this authorization at any time by sending a written notification to Custer Health attention Privacy Officer at 403 Burlington Street SE in Mandan, North Dakota 58554.

I understand that a revocation is not effective to the extent that Custer Health staff has relied on the use or disclosure of the protected health information.

I understand that the party receiving this information may disclose it with others, so the information disclosed may no longer be protected by federal or state law.

We will not condition your treatment on whether you provide this authorization for the requested use or disclosure.

You are not required to sign this authorization form. If you do sign this form, you have a right to receive a copy of the completed authorization.

☐ Please provide me with a copy of this authorization form.

Signature of Individual or Personal Representative_____ Date _____

Signature of Custer Health Staff_____ Date _____

(If Personal Representative, please provide proof of identity and/or describe authority):