Instructions for Universal Disclosure of Health Information Form

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



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.
- Indicate with which company/person(s) we can provide and/or discuss your health information with.
- To allow a person to verbally discuss your health information with Sanford Health Plan, initial this section.
- 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.
- **Q** 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.
- 1n 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			City					
2	I am requesting my health inform Sanford Health Plan OR Company or person(s) name		d from:					
3	Address	· 	d to or discussed with:City Fax	State	_ Zip			
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	OR To only release specific sections History and physical Progress notes Discharge summary Care plan	tructions to review tent: s of your health infourgical report aboratory report athology report ledications	what is included) formation, indicate categories to be released. Emergency room reports	ased:				
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:							

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Pa	tient/Member Name:							
•	Indiana who was specified to be forward.	ndicate why you want this information released						
8	Indicate why you want this information released.							
	☐ Patient/Member's request							
	☐ Review patient's current care	☐ Insurance application						
	☐ Treatment/continued care	☐ Payment	7.					
	□ Marketing purposes (payment or compensation involved? □ No □ Yes, amount) □ Other (please explain)							
	☐ Other (please explain)							
9	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 2 has already released health information based on my consent, my request to stop will not apply to the 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.							
	n named in section 3 is an insurance company, ew or different insurance; and/or I may not be al							
10	This consent will end when indicated belo	w or when the patient/mem	ber in section 1 reaches age 18:					
-	☐ No expiration date	☐ One year from	☐ One year from the date the form is signed					
	☐ On the following date:/	☐ When the follo	owing event occurs:					
	☐ When insurance coverage ends	☐ When I send r	notification					
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 sig	nature	Date					
	Representative's relationship to patient/me	ember	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.

SVHP-2026 Rev. 2/18 Page 2 of 2