GOOD SAMARITAN HOSPITAL ASSOCIATION
Heart of America Medical Center
Haaland Estates
800 South Main Ave, Rugby ND 58368-2118

Authorization for Use and Disclosure of Financial Account Information

Individual Whose Information will be released:

Name:_____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____

Authorized Use and/or Disclosure
By signing this form I am allowing Good Samaritan Hospital Association (Heart of America Medical Center) to use and disclose my financial information to the Authorized Representative(s) designated on this form. The authorization for the release and disclosure of financial information applies to: (check all that apply)

- ☐ All Financial Records
- ☐ Only dates of service from _____ to _____
- ☐ Only information pertaining to the treatment of _____
- ☐ Other _____

Authorized Representative #1:
Name:_____ Daytime phone number: _____

Address: _____

Relationship to you: _____

Authorized Representative #2:
Name:_____ Daytime phone number: _____

Address: _____

Relationship to you: _____

I also understand that I may revoke this authorization by submitting a **written** revocation to GSHA; however, this would not apply to any information already disclosed in good faith. To submit a revocation please contact the HIPAA Privacy Officer. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations. This authorization will remain in effect for 1 year unless one of the following is marked:

- ☐ From the date of this authorization until the following date: _____, 20___
- ☐ No expiration.

Print Name: _____

Signature:_____ Date: _____