

**Authorization to Release
Health Information**



PATIENT INFORMATION	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Health Care Provider – (Who has the information you want released?) Please list the specific Hospital and/or Clinic.	Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax Number: _____
Receiving Party (Where do you want the information sent? Who may have the information?)	Name: _____ Attention to: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax Number: _____
Information to be Released (What do you want sent or released? Check the appropriate box(es))	<input type="checkbox"/> Abstract (history & physical, discharge summary, operative reports, consults, clinic notes, progress notes, test results, labs, radiology reports, ER notes related to a specific timeframe) <input type="checkbox"/> Clinic Notes <input type="checkbox"/> Operative Notes <input type="checkbox"/> Labs <input type="checkbox"/> Verbal Information Only <input type="checkbox"/> Discharge Summary <input type="checkbox"/> ER Records <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Verbal Information & Any Copies <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Therapy Notes <input type="checkbox"/> Radiology Films <input type="checkbox"/> Allowed to View Records Other (Please Specify): _____ For the following service dates or condition: _____
Release Instructions (How and When do you want the information?)	Date information is needed: _____ Release Method: (check one) <input type="checkbox"/> Secure E-mail (E-mail address: _____) <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up **I may be charged for copies in accordance with state law.
Purpose of Release (Why is it needed?)	<input type="checkbox"/> Treatment/Continuing Care <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Transfer of care <input type="checkbox"/> Other _____

If applicable, this authorization includes release of any records regarding psychiatric care, alcohol and/or drug abuse, or HIV/AIDS-related disease diagnosis unless otherwise specified. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

I understand that I may revoke this authorization at any time by sending a written notice to the Manager of Health Information, United Hospital District. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the Manager of Health Information at United Hospital District.

This authorization will automatically expire one year from the date of signature unless I indicate an earlier date here: _____.

Your signature indicates that you have read and understand this form and authorize release of information as described above.

_____ Patient/Legal Guardian Signature	_____ Date	_____ Relationship/Legal Authority
*Any patient 18 or older must sign for themselves		
United Hospital District 515 S. Moore St. Blue Earth, MN 56013 Phone: 507-526-3273 Fax: 507-526-5341	Blue Earth Clinic 515 S. Moore St. Blue Earth, MN 56013 Phone: 507-526-7388 Fax: 507-526-2467	Wells Clinic 55 First St. SE Wells, MN 56097 Phone: 507-553-6550 Fax: 507-553-6559
		Winnebago Clinic 1 N. Main St. Winnebago, MN 56098 Phone: 507-893-3399 Fax: 507-893-3096
		Fairmont Clinic 221 E. 1 st St. Fairmont, MN 56031 Phone: 507-238-1287 Fax: 507-238-9070

Internal Use Only

Date Records Sent: _____
Completed by: _____

ID Verified by: _____
Method of Identification:
 Driver's License
 Signature Comparison
 Other: _____