

# AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Pt Sticker)

Patient Name: LAST FIRST MI

Date of Birth

Medical Record Number

I hereby authorize:  
(Name and address of releasing facility)

To Release Information to:  
(Individual name, facility/organization and address)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Including attached addendum

Date & Time of Appointment \_\_\_\_\_

**PURPOSE OF DISCLOSURE:**

- Continuing Care
- Payment of Claim
- School
- Worker's Compensation
- Legal
- For Personal Use
- Other

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released unless you restrict by initialing below:

*Initial*

- \_\_\_\_\_ Do not release Alcohol and/or Drug Abuse information
- \_\_\_\_\_ Do not release Behavioral Health information

(specify): \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

Between Dates of: \_\_\_\_\_ to \_\_\_\_\_

- |                                                        |                                                       |                                                             |
|--------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Diagnostic Imaging Reports   | <input type="checkbox"/> Transfer/Outside Information       |
| <input type="checkbox"/> H&P Exam/ER Evaluation        | <input type="checkbox"/> Diagnostic Imaging CD        | <input type="checkbox"/> Completed Form                     |
| <input type="checkbox"/> Consult                       | <input type="checkbox"/> Diagnostic Test Reports      | <input type="checkbox"/> Exchange of Verbal Communication   |
| <input type="checkbox"/> Therapist Reports             | <input type="checkbox"/> Procedure Reports/anesthesia | <input type="checkbox"/> Correspondence                     |
| <input type="checkbox"/> Progress Notes/Provider Notes | <input type="checkbox"/> Lab/Pathology Reports        | <input type="checkbox"/> Other (specify content and dates): |
| <input type="checkbox"/> Orders                        |                                                       | _____                                                       |

HIV related information (AIDS related testing)

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

- I understand the expiration date of this authorization is \_\_\_\_\_ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that EBCH may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.335, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as the original.

Employee releasing health information  
\_\_\_\_\_ *Initials* \_\_\_\_\_ *Date* \_\_\_\_\_

*If I am signing as Authorized Representative of the patient, I am:*

- Parent of minor
- Court appointed guardian/conservator

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Relationship to Patient



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