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 (specify):____

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

INFORMATION TO BE RELEASED: Between Dates of: _______________ to ___________________

☐Discharge Summary
☐H&P Exam/ER Evaluation
☐Consult
☐Therapist Reports
☐Progress Notes/Provider Notes
☐Orders
☐HIV related information (AIDS related testing)

☐Diagnostic Imaging Reports
☐Diagnostic Imaging CD
☐Diagnostic Test Reports
☐Procedure Reports/anesthesia
☐Lab/Pathology Reports

☐Transfer/Outside Information
☐Completed Form
☐Exchange of Verbal Communication
☐Correspondence
☐Other (specify content and dates):
____

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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