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 in writing 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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