

AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION
(Release of Patient Information)

Stevens Community Medical Center
400 East First St., PO Box 660
Morris, MN 56267 **Fax#** 320-589-1065
320-589-1313 **Med Rec #** 320-589-7642

Patient Name (Last - First - Middle)	
Previous Last Name (if any)	Date of Birth
Street Address/Rural Route	Telephone
City	State
Zip Code	Medical Record #

Instructions: Check applicable box in each section. When OTHER is checked, explain or describe as instructed.

*****ALL PORTIONS MUST BE COMPLETED FULLY BY PATIENT*****

PROVIDER Who has the information you would like released?	<input type="checkbox"/> Stevens Community Medical Center 400 East First Street, PO Box 660 Morris, MN 56267	Or <input type="checkbox"/> Other _____ _____ _____
REQUESTOR Who should the information be sent to? (Name/Address)	<input type="checkbox"/> STEVENS COMMUNITY MEDICAL CENTER 400 East First Street, PO Box 660 Morris, MN 56267 Attn: _____	Or <input type="checkbox"/> Other _____ _____ _____
PURPOSE OF INFORMATION RELEASE	<input type="checkbox"/> Continuation of Medical Care (Date of Appointment _____) <input type="checkbox"/> Insurance Application <input type="checkbox"/> Disability Determination <input type="checkbox"/> Personal Records <input type="checkbox"/> Payment of Insurance Claims <input type="checkbox"/> Legal <input type="checkbox"/> Other _____ <input type="checkbox"/> Consult / second opinion <input type="checkbox"/> Out of town move _____	
INFORMATION SHOULD INCLUDE	<input type="checkbox"/> Clinic Chart Notes from _____ (date) to _____ (date) <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> EKG Reports <input type="checkbox"/> X-Ray films <input type="checkbox"/> EEG Reports <input type="checkbox"/> Lab Data _____ <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Physicians IP Progress Notes <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Operative Reports <input type="checkbox"/> Outpatient Notes <input type="checkbox"/> Surgical Pathology Reports <input type="checkbox"/> Other _____	

1. Covering records for the period from _____ (date) to _____ (date)

2. Confined to the following specified information: _____

I understand that the information in my health record may include information related to alcohol or drug abuse, sickle cell anemia or psychological and/or psychiatric conditions and for testing and/or treatment of HIV, or AIDS and STD'S.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following, date, event, or condition: _____.

If I fail to specify an expiration date, event, or condition, this authorization will expire in one year. A photocopy of this authorization is as valid as the original form with my original signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Treatment will still be provided to me if I do not sign this form. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed.

Signature of person releasing information (Patient/Guardian)	Date signed	Witness
*Relationship to patient, if signed by other person	Reason patient unable to sign	

***If you are the legal responsible party acting on behalf of the patient, please provide legal documentation.**

