STEVENS COMMUNITY MEDICAL CENTER
400 East First Street ● Morris MN 56267
Phone # 320.589.7642 ● Fax # 320.589.1065

# AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

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|---|---|
| **PATIENT INFORMATION** | **NAME:** _____ **DATE OF BIRTH:** _____<br>**Previous / Maiden Name:** _____<br>**Address:** _____ **Phone:** _____<br>**City:** _____ **State:** _____ **Zip:** _____ |
| **Clinic/Hospital/Health Care Provider –**<br>(***Who*** has the information you want released?) **Please list the specific Hospital and/or clinic.** | **NAME:** _____<br>**Address:** _____ **Phone:** _____<br>**City:** _____ **Fax:** _____<br>**State:** _____ **Zip:** _____ |
| **Receiving Party**<br>(***Where*** do you want the information sent? ***Who*** may have the information?) | **NAME:** _____ **Attention to:** _____<br>**Address:** _____ **Phone:** _____<br>**City:** _____ **Fax Number:** _____ **(HEALTHCARE FACILITY ONLY)**<br>**State:** _____ **Zip:** _____ |
| **Information to be Released**<br>(***What*** do you want sent or released? Check the appropriate box.) | Routine Records **Service Dates: From:** _____ **To:** _____<br>□ Clinic (office visit, lab, radiology, medicines, immunizations)<br>□ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)<br>□ Billing Records<br>□ Copies of Films / Images<br>□ Alcohol and / or Drug Treatment records<br>□ HIV/AIDS □ STD □ Mental Health (Psychotherapy Notes – require a separate release)<br>**Only check record types to be released below:** |

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| □ Discharge Summary<br>□ History & Physical Exam<br>□ Operative Report<br>□ Consultations | □ Progress Notes/ Clinic Notes<br>□ Rehab Records (PT/OT/ST)<br>□ Laboratory Reports<br>□ Pathology Reports | □ Emergency Record(s)<br>□ X-ray / Radiology Reports<br>□ EKG / Echo / Cardiology<br>□ Medication Records | □ Immunization Record<br>□ Allergy / Immunology Record<br>□ **Entire Medical Record** |

□ Other records specify record type(s) _____

OPTIONAL Limits – Disclose only records related to following injury or illness: _____

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| **Release Instructions**<br>(***How*** and ***When*** do you want the information?) | **Date information is needed:** _____ **(NOTE: PLEASE ALLOW 5 - 7 DAYS FOR PROCESSING)**<br>**Release Method / Format requested: (check one)**<br>**□ Mail □ View my Record □ Fax (patient care only) □ Pickup – picture ID may be required. If someone other than you are picking up your records, print their name here:** _____ |
| Purpose of Release<br>(***Why*** is it needed?) | □ **Continuing care** □ **Transfer of care** □ **Social security appeal**<br>□ **Insurance application*** □ **Personal use or review*** □ **Social security disability determination***<br>□ **Insurance payment/claim** □ **Litigation/legal***<br>***Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524** |

This authorization lasts for a maximum of **one year** after the date you sign it unless you enter a different date or expiration here: _____

- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. Stevens Community Medical Center Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- Stevens Community Medical Center will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Stevens Community Medical Center records may include records that it received from other organizations. If these records have been used by Stevens Community Medical Center and filed in the record Stevens Community Medical Center maintains about you, these records may be released with your Stevens Community Medical Center records.
- Stevens Community Medical Center cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, and that information, you release Stevens Community Medical Center from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____
Patient / Legal Guardian Signature Date

_____ _____
Authority to act on behalf of patient (attach document) Date

Routing: Scan into Chart Maxx
(Auth for Release of Info - S) → Shred

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