915 E. 1st Street | Duluth, MN 55805

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:	Last Name: __________________ First Name: __________________ Date of Birth: _________________
I HEREBY AUTHORIZE:	Name: ______________________________ Address: ______________________________ City: ______________________ State: ____________ Zip: ________________
TO RELEASE INFORMATION TO:	Name: ______________________________ Address: ______________________________ City: ______________________ State: ____________ Zip: ________________ Fax (patient care only): ______________________________
PURPOSE OF DISCLOSURE:	( ) Continuing Care ( ) Payment of Claim ( ) School ( ) Worker's Compensation ( ) Legal ( ) Personal Use ( ) Other (specify): ____________ **RELEASE METHOD:** ( ) Mail ( ) Fax (patient care only) ( ) Pick-up ( ) Email: ______________________________
DATE INFORMATION IS NEEDED:	________________________ (Note: Please allow 7-10 days for processing)
INFORMATION TO BE RELEASED:	Between dates of: ________________________ and ________________________
	Routine Record Set: ( ) Abstract (Provider Notes, Procedure Reports, H&P Exam, Discharge Summary, Radiology/Diagnostic Reports, Lab Reports)
	( ) Discharge Summary ( ) Orders ( ) Procedure Reports ( ) H&P Exam/Initial Evaluation ( ) ER/Urgent Care/QCare/eCare ( ) Lab/ Pathology Reports ( ) Consultation Report ( ) Radiology/MRI Reports ( ) Immunization Records ( ) Rehab Records (PT/OT/ST) ( ) Radiology/MRI Films ( ) Itemized Billing Statement ( ) Progress Notes/Provider Notes ( ) Diagnostic Test Reports ( ) Verbal Discussion w/ Provider ( ) Condition Report ( ) Other (specify content/dates): ____________________

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year after the date signed.
- 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.
- 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 by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that in compliance with MN Statute 144.292 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.
- Psychotherapy notes will not be released per facility policy and HIPAA privacy rules, 45 CFR Parts 160 and 164, 164.502.

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Signature of patient or legally authorized representative	Relationship	Date/Time	Phone