

## AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**The Provider**

*Who has the information that you would like to have released? (name and address)*

- |   |  |
|---|--|
| <input type="checkbox"/> Hospital: _____<br>_____<br>_____<br><input type="checkbox"/> Doctor/clinic: _____<br>_____<br>_____ | <input type="checkbox"/> Other (provide name and address): _____<br>_____<br>_____<br>_____<br>_____ |
|---|--|

**Complete one form for each provider.**

**The Requester**

*To whom should the information be sent?*

- |   |  |
|---|--|
| <input type="checkbox"/> <b>FamilyHealth Medical Clinic - Farmington</b><br>4645 Knutsen Drive, Farmington, MN 55024-8455<br>Phone: (651) 460-2300 • Fax: (651) 460-2301      | <input type="checkbox"/> <b>Orthopaedic &amp; Fracture Clinic</b><br>1381 Jefferson Road, Northfield, MN 55057-3080<br>Phone: (507) 646-8900 • Fax: (507) 646-8904 |
| <input type="checkbox"/> <b>FamilyHealth Medical Clinic - Lakeville</b><br>9974 - 214th Street, West, Lakeville, MN 55044-1914<br>Phone: (952) 469-0500 • Fax: (952) 469-0505 | <input type="checkbox"/> <b>Women's Health Center</b><br>2000 North Avenue, Northfield, MN 55057-1697<br>Phone: (507) 646-1478 • Fax: (507) 646-6870               |
| <input type="checkbox"/> <b>FamilyHealth Medical Clinic - Northfield</b><br>2000 North Avenue, Northfield, MN 55057-1697<br>Phone: (507) 646-1494 • Fax: (507) 646-6870       | <input type="checkbox"/> <b>Northfield Hospital</b><br>2000 North Avenue; Northfield, MN 55057-1697<br>Phone: (507) 646-1182 • Fax: (507) 646-1192                 |
| <input type="checkbox"/> <b>FamilyHealth Medical Clinic - Lonsdale</b><br>103 - 15th Avenue S.E., Lonsdale, MN 55046-5001<br>Phone: (507) 744-3245 • Fax: (507) 744-3247      | <input type="checkbox"/> <b>Center for Sports Medicine and Rehabilitation</b><br>1381 Jefferson Road<br>Phone: (507) 646-8800 • Fax: (507) 646-8801                |

**The information to be sent should include...**

- |   |   |
|---|---|
| <input type="checkbox"/> All Record of Treatment<br><input type="checkbox"/> Discharge Summaries<br><input type="checkbox"/> Operative Reports<br><input type="checkbox"/> Pathology Reports<br><input type="checkbox"/> History and Physical<br><input type="checkbox"/> Permanent Transfer of All Mammography Films<br><input type="checkbox"/> Lab data, including: _____<br>_____<br>_____<br>_____ | <input type="checkbox"/> Outpatient Reports<br><input type="checkbox"/> X-ray Reports<br><input type="checkbox"/> E.K.G. Reports<br><input type="checkbox"/> Consultation Reports<br><input type="checkbox"/> Immunization Records<br><input type="checkbox"/> Other, including: _____<br>_____<br>_____<br>_____ |
|---|---|

**Special Authorization** (Check the applicable box[es] and sign immediately below.)  
 By signing below, I am authorizing the office to release any and all information regarding:

<input type="checkbox"/> Alcohol	<input type="checkbox"/> HIV	<input type="checkbox"/> Sexually-Transmitted Diseases
<input type="checkbox"/> Drugs	<input type="checkbox"/> AIDS	<input type="checkbox"/> Mental Health

**Note** — If this release pertains to alcohol, drugs, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Purpose for release of information**

- Treatment and related uses
- Other (explain): \_\_\_\_\_  
 \_\_\_\_\_

I give permission to the PROVIDER to release Medical Record Information to the above-named physician, facility, or person named above. The information released will be restricted by any INFORMATION LIMITATIONS outlined above, and may be used only for the purposes described.

I understand that this release will take effect on the date signed and will be in effect for one year.

I understand that I can cancel this release at any time by notifying the PROVIDER in writing that my cancellation will take effect when the PROVIDER received my written notice. I understand that my cancellation will not have any effect on information released before the PROVIDER received my written notice. Health information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I understand that I am entitled to receive a copy of this authorization.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient is:**  a minor.  incompetent.  disabled.  deceased.

**Legal authority:**  legal guardian  parent of minor  next-of-kin of deceased