

**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)

- Hospital: _____ Other (provide name and address): _____
- _____
- _____
- Doctor/clinic: _____
- _____
- _____

Complete one form for each provider.

The Requester

To whom should the information be sent?

- FamilyHealth Medical Clinic - Farmington
4645 Knutsen Drive, Farmington, MN 55024-8455
Phone: (651) 460-2300 • Fax: (651) 460-2301
- FamilyHealth Medical Clinic - Lakeville
9974 214th St. W., Lakeville, MN 55044-1914
Phone: (952) 469-0500 • Fax: (952) 469-0505
- FamilyHealth Medical Clinic - Northfield
2000 North Avenue, Northfield, MN 55057-1697
Phone: (507) 646-1494 • Fax: (507) 646-6870
- FamilyHealth Medical Clinic of Lonsdale
103 - 15th Avenue S.E., Lonsdale, MN 55046-5001
Phone: (507) 744-3245 • Fax: (507) 744-3247
- Orthopaedic and Fracture Clinic of Northfield
1381 Jefferson Road, Northfield, MN 55057-3080
Phone: (507) 646-8900 • Fax: (507) 646-8904
- Women's Health Center of Northfield Hospital
2000 North Avenue, Northfield, MN 55057-1697
Phone: (507) 646-1478 • Fax: (507) 646-6870

The information to be sent should include...

- All Record of Treatment
- Discharge Summaries
- Operative Reports
- Pathology Reports
- History and Physical
- Permanent Transfer of All Mammography Films
- Lab data, including: _____
- _____
- _____
- Outpatient Reports
- X-ray Reports
- E.K.G. Reports
- Consultation Reports
- Immunization Records
- Other, including: _____
- _____
- _____

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:

- Alcohol HIV Sexually-Transmitted Diseases
- Drugs AIDS 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