Chippewa County – Montevideo Hospital/Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

I , ______________________________ ________________ ___________________________________ hereby authorize you to
(Name of Patient) (Date of Birth) (Phone Number)

release the following information from my medical records:

Name of Facility		Name of Facility	
	FROM: ______________________		**TO:** ______________________
	Address:______________________		Address:______________________
	City, State, Zip: ______________________		City, State, Zip ______________________
	Phone # ______________________		Phone #:______________________
	Fax #: ______________________		Fax #: ______________________

Purpose of Release:____

From (Date)______________________________ To (Date)______________________________

Check all the apply:

____Discharge Summary
____Pathology Report
____EKG/EEG Reports
____Outpatient Clinic Notes
____History & Physical
____Laboratory Results
____Emergency Room Reports
____Consultation Reports
____Operative Reports
____X-Ray Reports
____Prenatal Records
____Therapy Notes

____Other (Please Specify)____

SPECIFIC AUTHORIZATON FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I acknowledge that information to be released may include material that is protected by Federal and/or State law relative to sexually transmitted disease, acquired immunodeficiency syndrome(AIDS) or human immunodeficiency virus(HIV). It may also include information about mental health services or treatment for alcohol and/or drug abuse.

I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO:

Put "Yes" *or* "No" next to all spaces provided

________ Substance abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

________ Mental health information from all health care providers and facility and any other person or entity in possession of records concerning me.

________ HIV or AIDS related information, diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

I understand that I have the 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 medical records department. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that this 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 six months from the date I signed it**.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the privacy officer.

______________________________ ______________________________
Signature of Patient/Legal Representative | Relationship to Patient if signed by Legal Representative

______________________________ ______________________________
Date | Witness