



Northfield Hospital and Clinics

# AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION



FamilyHealth Medical Clinics

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
- Northfield Hospital**  
2000 North Avenue; Northfield, MN 55057-1697  
Phone: (507) 646-1182 • Fax: (507) 646-1192

### 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