

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's name: _____ **Date of birth:** _____

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

To release copies of the following information:

- | | | |
|-----------------------------------------------------|-----------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Outpatient Reports | <input type="checkbox"/> Entire Medical Chart |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Other, including: _____ |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> E.K.G. Reports | _____ |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Reports | _____ |
| <input type="checkbox"/> Lab Data, including: _____ | <input type="checkbox"/> Immunization Records | _____ |
| _____ | <input type="checkbox"/> Office Visit Notes | _____ |

Purpose of disclosure: Treatment or Other _____

Special Authorization (Check the applicable box[es] and sign 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"/> Mental Health
<input type="checkbox"/> Drugs	<input type="checkbox"/> AIDS	<input type="checkbox"/> Sexually Transmitted Diseases

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 the 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.

Please send records to: **Name of clinic:** _____
Address: _____
City: _____
State: _____ **Zip code:** _____

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 receives 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.

We will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization OR we will describe the consequences of refusal to sign an authorization.

Signature of patient/parent/guardian _____
Date

Relationship to patient _____
Reason that patient is unable to sign