MILLE LACS HEALTH SYSTEM

PO Box A   Onamia MN 56359 Fax:(320) 532-2399

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ____Date of Birth_____________________

Address:____

Release Information From:	Release Information to:
Name/Facility ____ Address:______________________________________ City/State/Zip __________________________________	Name/Facility ____ Address:______________________________________ City/State/Zip __________________________________

Purpose of Release:

☐ Further Medical Care ☐ Work Comp ☐ Insurance ☐ Relocation/Moving ☐ Attorney/Legal
☐ Personal ☐ Change of Provider ☐ Other (comments)________________________

Delivery Method

Check **1** of 2 options only

1. ☐ Paper via ☐ Mail OR ☐ Pick Up (date__________________) OR ☐ Fax #_______________________

2. ☐ CD ROM ☐ Mail OR ☐ Pick Up (date__________________)

Information to be released

Date of Service From:_____________________ **To**:____________________________

( ) Info. Necessary for Cont. Care	( ) Discharge Summary
( ) History and Physical	( ) Operative Procedure Report
( ) Pathology Report	( ) Consultations
( ) Labs	( ) X-Rays
( ) EKG/EMG/EEG	( ) Progress Notes
( ) Immunizations	( ) Other:____

In compliance with Minnesota Statutes that require special permission to release otherwise privileged information, please release records pertaining to:

( ) Alcohol/Drug Abuse or test results ( ) Mental Health	( ) HIV test results, AIDS or AIIDS related disease
( ) Developmental Disabilities	( ) Sexually transmitted disease

REDISCLOSURE NOTICE: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient and is no longer protected by Federal Privacy standards. A photocopy or facsimile/scanned image will be treated as an original.

Your rights with respect to this authorization:

I understand that I have the right to: Inspect or copy the health information I have authorized to be used or disclosed by this authorization form; to receive a copy of this authorization; to refuse to sign this authorization; to revoke this authorization unless the request has previously been completed.

EXPIRATION DATE: Unless otherwise specified, this authorization will expire on________________or one year from date signed

Signed:____ ___________________________

(or Signature of Personal Representative) Date of Signature

____ ____

Printed name of representative and Reason Patient is unable to sign

Office use only

Date Received_____________ Date Completed_____________ HI Signature_________________