MILLE LACS HEALTH SYSTEM

200 North Elm St - PO Box A - Onamia, MN - 56359
Phone:(320) 532-3154 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
( ) History and Physical
( ) Pathology Report
( ) Labs
( ) EKG/EMG/EEG
( ) Immunizations
( ) Discharge Summary
( ) Operative Procedure Report
( ) Consultations
Radiology Imaging- ( ) Reports ( ) CD ( ) Mammo (includes report & CD)
( ) Progress Notes
( ) 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 ( ) Developmental Disabilities	( ) HIV test results, AIDS or AIIDS related disease ( ) 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_____

Return to Health Information