

United Hospital District

515 South Moore Street
Blue Earth, MN 56013
507-526-3273
507-526-4411 (TTY)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name _____ Date of Birth _____ MR# _____
Last First Middle

Address _____
(Street) (City) (State) (Zip Code)

I, the undersigned, hereby authorize _____ to release information concerning the above named patient to:
(Name of facility releasing information)

Name of Person or Institution Receiving Information: _____

(Street) (City) (State) (Zip Code) (Fax # if applicable)

The health information will contain copies that pertain to the patient's evaluation and treatment. Please specify the type of reports to be copied, the diagnosis/procedure, and the dates of service.

___ Discharge Summary ___ History & Physical Exam ___ Consultation Reports
___ Clinical Notes/Orders ___ Diagnostic Tests ___ OTHER (Please Specify) _____
___ Operative Record ___ ER records

Diagnosis/Procedure/Injury _____

Dates of Service _____

Purpose of Disclosure (Check One) ___ Continuing Care ___ Legal ___ Insurance ___ Other: _____

Specific Authorization for Release of Information Protected by State or Federal Law

This information has been disclosed to you from records protected by federal confidentiality rules for alcohol/drug abuse records (42 CFR Part 2), state law for mental health records, and/or state law for HIV records. These rules/laws prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical information or other information is not sufficient for this purpose. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of this information. The federal rules relating to alcohol/drug abuse records restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically authorize the release of data and information relating to: (Please initial all that are appropriate)

- ___ 1. Substance Abuse (alcohol/drug abuse)
___ 2. Mental Health (including psychological testing)
___ 3. HIV/AIDS- Related Information
___ 4. Not Applicable

This authorization will automatically expire 180 days from the date of signature, except as specified _____
(Specific number of days or months)

At this time, no expressed revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to the Director of Health Information, United Hospital District. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the Director of Health Information, United Hospital District. I understand that any disclosure of my Protected Health Information carries with it the potential for re-disclosure by the recipient and the Protected Health Information may not be protected by the federal privacy rules.

(Signature of Patient or Legal Guardian) (Date)

(Relationship, if not the patient) (Witness)

Date Records Sent: _____ ID Verified by: _____
Completed By: _____ Method of Identification: _____
___ Drivers License
___ Signature Comparison
___ Other: _____