Authorization to Release Health Information

UHD
UNITED HOSPITAL DISTRICT

PATIENT INFORMATION	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Health Care Provider – (***Who*** has the information you want released?) **Please list the specific Hospital and/or Clinic.**	Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax Number: _____
Receiving Party (***Where*** do you want the information sent? ***Who*** may have the information?)	Name: _____ Attention to: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax Number: _____
Information to be Released (***What*** do you want sent or released? Check the appropriate box(es))	☐ Abstract (history & physical, discharge summary, operative reports, consults, clinic notes, progress notes, test results, labs, radiology reports, ER notes related to a specific timeframe) ☐ Clinic Notes ☐ Operative Notes ☐ Labs ☐ Verbal Information Only ☐ Discharge Summary ☐ ER Records ☐ Radiology Reports ☐ Verbal Information & Any Copies ☐ History & Physical Exam ☐ Therapy Notes ☐ Radiology Films ☐ Allowed to View Records Other (Please Specify): _____ For the following service dates or condition: _____
Release Instructions (***How*** and ***When*** do you want the information?)	**Date information is needed:** _____ **Release Method: (check one)** ☐ Secure E-mail *(E-mail address*: _____) ☐ Fax ☐ Mail ☐ Pick Up ****I may be charged for copies in accordance with state law.**
Purpose of Release (***Why*** is it needed?)	☐ Treatment/Continuing Care ☐ Legal ☐ Insurance ☐ Transfer of care ☐ Other _____

If applicable, this authorization includes release of any records regarding psychiatric care, alcohol and/or drug abuse, or HIV/AIDS-related disease diagnosis unless otherwise specified. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.
I understand that I may revoke this authorization at any time by sending a written notice to the Manager 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 Manager of Health Information at United Hospital District.

This authorization will automatically expire one year from the date of signature unless I indicate an earlier date here: _____.

Your signature indicates that you have read and understand this form and authorize release of information as described above.

_____ _____ _____
Patient/Legal Guardian Signature | Date | Relationship/Legal Authority
*Any patient 18 or older must sign for themselves

United Hospital District
515 S. Moore St.
Blue Earth, MN 56013
Phone: 507-526-3273
Fax: 507-526-5341

Blue Earth Clinic
515 S. Moore St.
Blue Earth, MN 56013
Phone: 507-526-7388
Fax: 507-526-2467

Fairmont Clinic
221 E. 1st St.
Fairmont, MN 56031
Phone: 507-238-1287
Fax: 507-238-9070

Wells Clinic
55 First St. SE
Wells, MN 56097
Phone: 507-553-6550
Fax: 507-553-6559

Internal Use Only

Date Records Sent: _____
Completed by: _____

ID Verified by: _____
Method of Identification:
☐ Driver's License
☐ Signature Comparison
☐ Other: _____

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