

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CENTER FOR SPECIALTY CARE
 717 S. State Street, Suite 900, Fairmont, MN 56031
 507-238-4949

Patient Name: _____ Date of Birth: _____

Address: _____

I hereby authorize _____

to release the following medical information in its possession, including medical information in any form including oral, written, or recorded information and which may comprise or contain "Protected Health Information" under the Health Insurance Portability and Accountability Act ("HIPAA").

Disclose to _____ Telephone Number _____

Address _____

Information to be released: _____ Treatment Dates: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Physician Notes | <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Radiology Films |
| <input type="checkbox"/> Consultation by Dr. _____ | | <input type="checkbox"/> Laboratory Data |
| <input type="checkbox"/> Other-specify _____ | | <input type="checkbox"/> EKG Reports |

I understand that there are no limitations placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health, behavior or psychiatric treatment.

I understand that this authorization is executed for purposes of _____ and that the Protected Health Information is being released for purposes related to that matter. I also understand that the Protected Health Information may be subject to state and federal law, but I expressly authorize the release of such information as specified herein. I understand that once this information is released, the Center for Specialty Care can no longer control or be responsible for its use or redisclosure. I understand that the Center for Specialty Care cannot take back information that has already been released in response to this authorization. Once released, the information may no longer be protected under HIPAA.

I understand that the Center for Specialty Care cannot condition treatment, payment, enrollment, or eligibility for benefits upon execution of this authorization, if prohibited by HIPAA.

I may revoke this authorization at any time except to the extent that the Center for Specialty Care has taken action in reliance upon it. In order to revoke this authorization, I must submit a written request to the Center for Specialty Care. If not previously revoked, this authorization will expire one year from the date set forth below.

I know that I have the right to receive a copy of this authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

A copy of this authorization will be considered as valid and enforceable as the original and that the healthcare organization, may deny the release of Protected Health Information, if it has reason to believe (1) this authorization has been altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested.

 Patient's Signature (Photo identification may be required) _____ Date _____

 Signature of Other Individual _____ Relationship to Patient _____

FOR OFFICE USE ONLY

Medical Record Number _____ Total number of Pages _____
 Copy to X-ray _____ Date Copies were mailed/picked up _____
 Initials _____