

DULUTH FAMILY PRACTICE CENTER
330 North Eighth Avenue East, Duluth, MN 55805 218/723-1112 218/529-9120 fax

Authorization for Disclosure of Health Information

PLEASE PRINT

Patient Name/Previous Names _____

Street Address _____

Date of Birth _____ Phone Number _____

City, State, Zip _____

I HEREBY AUTHORIZE:

Physician and/or Facility _____ Street Address _____ City/State/Zip _____

TO: Release confidential **written** information to: Exchange confidential **verbal** information with:

Physician / Facility/Other _____ Street Address _____ City/State/Zip _____

PURPOSE(S) OF THIS DISCLOSURE:

- Transfer to another Clinic Insurance
- Continued Care Personal Use
- Litigation/Attorney Use Other _____

DATES OF INFORMATION TO BE RELEASED:

- All Dates
- From ____ / ____ / ____ to ____ / ____ / ____

SPECIFIC INFORMATION TO BE RELEASED:

- Any and all Medical Records History and Physical
- Immunization Records X-ray Reports
- Physician Office Notes Other Diagnostic Test Results (Specify) _____
- Laboratory Reports
- Medical Records regarding treatment for _____
(Specific Medical Condition or Injury)
- Other: _____

ALL RECORDS PERTAINING TO MENTAL HEALTH, ALCOHOL ABUSE, DRUG ABUSE, HIV, AIDS OR AIDS RELATED DISEASE, AND SICKLE CELL ANEMIA WILL BE RELEASED UNLESS OTHERWISE INDICATED HERE IN WRITING: _____

REDISCLASURE NOTICE: I understand that the information disclosed through this authorization may be redisclosed by the recipient and/or may be no longer protected by federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to receive a copy of the health information to be used or disclosed-I understand that I have the right to receive a copy of the health information I have authorized to be used or disclosed by this authorization form.

Right to receive a copy of this authorization - I understand that I will receive a copy of this authorization form upon my request.

Right to refuse to sign this authorization - I understand that I am under no obligation to sign this form. Treatment, payment, enrollment in a health plan, or eligibility to obtain health care benefits cannot be denied based on my refusal to sign this authorization. (Exceptions: Certain care is done solely for the purpose of creating information to release to another party. In these cases, care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for services provided.

Right to revoke this authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Health Information Services Department. I am aware that my withdrawal will not affect releases of information that have already occurred subsequent to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have reviewed and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative _____ **Date** _____

If signed by someone other than patient, state relationship and authority to sign:

- Parent Guardian POA for HealthCare Parent or Spouse of deceased patient (specify relationship to patient)