P.O. BOX 335 | 519 SOUTH GALBRAITH STREET
BLUE EARTH, MN 56013
phone 507.526.3460
fax 507.526.3428

Authorization for Release of Health Information

Name *(First, Middle, Last, Previous/Maiden)* ____________ ____________ ____________ ____________

Address ______________________________ Date of Birth ____|____|____

City ____________ State ______ Zip ________

Information to be:
☐ Mailed ☐ Picked-up ☐ Faxed

Phone Number ____________ Medical Records No. ____________ Date needed by ____________

Release Information

I, hereby authorize ______________________________
(Name of facility releasing information)

to release information concerning the above named patient to:

Name of person or institution receiving information:

____
____
____
(Address, City, State, Zip and Contact)

Purpose of Disclosure

- ☐ Continuing Care
- ☐ Legal
- ☐ Insurance
- ☐ Other (please specify) ____________

Information to be Disclosed

Please specify the types of reports to be copied, the diagnosis/procedure and the dates of service.

Diagnosis/Procedure/Injury: ____________
Dates of Service: ____________

- ☐ Physician progress notes for two years
- ☐ Preventive Health flow sheet
- ☐ Immunization Records
- ☐ Current Medication lists
- ☐ Ancillary services (lab, x-ray, EKG, pathology)
- ☐ Hospital history and physical exams
- ☐ Hospital discharge summaries
- ☐ Operative notes
- ☐ Consultation Reports
- ☐ Dietitian notes
- ☐ Other (please specify) ____________

Authorization for Release of Information Protected by State or Federal Law

This information has been disclosed to your 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 an alcohol or drug abuse patient. I specifically authorize the release of information relating to:
☐ Substance Abuse (alcohol/drug abuse) ☐ Mental Health (including psychological testing) ☐ HIV/AIDS-Related Information

Authorization

I understand that Southern Minnesota Surgical, Inc. cannot condition treatment based on my signing or not signing this authorization. I also understand that I may be responsible for any charges associated with transfer of this information.

I understand that I may revoke this consent at any time, but that such a revocation will only be effective upon written notice to Southern Minnesota Surgical, Inc. I do not authorize re-disclosure of this information to anyone, but understand that in the event there is an unauthorized disclosure by the recipient of this information, the protected health information is no longer protected by federal privacy guidelines. This authorization will automatically expire one year from the date of my signature.

______________________________ ____________
Signature Date of Signature
(Any patient 18 or older, must sign for themselves. If signed by a person other than patient, state relationship and authority below.)

____________ ____________
Relationship to Patient Legal Authority

FOR OFFICE USE ONLY. INFORMATION: Date Records Sent/Given: ____________ Completed By:____________ID Verified By:____________,
Method of Identification:____________