



Authorization for Disclosure of Protected Health Information - CLINIC

Print Patient's legal name Previous Names
Address, City, State Zip Birth date
Phone numbers (Home) (Work) (Other)

This form, when completed and signed, authorizes the parties below to release and/or exchange protected information from records.

I authorize: All RMC Clinics or: Belle Plaine Chanhassen Chaska Delano Excelsior Howard Lake Le Sueur Westonka Winsted Specialty Clinic RMC Sibley

Clinic Address: , MN Zip Code:
Fax: or 952-442-6037 Phone: (952) 777-4174

To release TO or RECEIVE FROM the following party:

Person, clinic or organization:

Address: City:

State: Zip code: Phone: Fax:

To release and/exchange the following information: Any and all records (includes all types of records listed below):

- Progress Notes Itemized Bills Lab/Pathology Reports Consult Reports by Dr.
Radiology Films/Images Radiology Reports Pre-Employment Records hospital/medical center reports
Other:

For condition or dates of treatment: (If blank, we will release 1 year's worth of most recent records.)

I would like to receive my records by: I will pick up Mail Email

I understand the following:

Except for psychotherapy notes (which are not included in my medical record), all records of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV will be released. If I don't want these to be released, I will place a checkmark here: I DO NOT want the following records released:

- Alcohol/Drug Use or Abuse Records Mental Health Records AIDS/HIV Records Sickle Cell Genetic Conditions

Purpose of Disclosure:

- Continued care by another provider Insurance claim Personal use Transfer of Care Moving
Coordination of Services Legal Other

If releasing records to yourself, should the envelope be marked "Personal and Confidential"? Yes No

This form expires one year after I sign it or sooner (specify here: ). The time period noted here may exceed one year in certain situations specified by law.

I understand that I may revoke this authorization at any time by sending written notice to the health facilities noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy. Once the records are released, Ridgeview Medical Center cannot prevent them from being released to a third party. At that point, the records may no longer be protected by state and federal privacy laws.

I hereby authorize the above facilities to disclose medical information concerning the above named patient. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, also HIV related information. I understand that once information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits.

X X
Date Signature of client or authorized person Authorized person's authority to sign

Reason patient is unable to sign: Minor Deceased Other:

To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.

Office Use: Mailed Faxed Patient Pickup Email Identification Verified Initials Date: