Authorization for Disclosure of Protected Health Information - HOSPITAL

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:

Ridgeview Medical Center
500 South Maple St, Waconia, MN 55387
Fax (952) 442-6037 or (952) 442-6538 | Phone: (952) 777-4174 or ext 35188 / 35698

To release ☐ TO ☐ RECEIVE FROM the following party:

Person, clinic or organization: _____

Address:_____City: _____

State:_____Zip code:_____Phone:_____-_____-_____Fax:_____-_____-_____

the following information: ☐ Any and all records (includes all types of records listed below):

☐ History/Consults/ED ☐ Physical Therapy ☐ Itemized Bills ☐ Operative Reports/Pathology

☐ Pathology Slides ☐ Progress Notes ☐ Radiology Films/Images ☐ Discharge Summary ☐ Radiology/Lab Report

☐ 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

☐ 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 redisclosure 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.

_____ _____ _____

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: _____

MR#:_____Visit ID: _____