AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION

(Release of Patient Information)

Stevens Community Medical Center
400 East First St., PO Box 660
Morris, MN 56267
Phone# 320-589-1313 **Med Rec #** 320-589-7642
Fax# 320-589-1065 www.scmcinc.org

Patient Name (Last - First - Middle)		
Previous Last Name (if any)	Date of Birth	
Street Address/Rural Route	Telephone	Medical Record #
City / State	Zip Code	

Instructions: Check applicable box in each section. When OTHER is checked, explain or describe as instructed.

*****ALL PORTIONS MUST BE COMPLETED FULLY BY PATIENT*****

PROVIDER Who has the information you would like released?	☐ Stevens Community Medical Center 400 East First Street, PO Box 660 Morris, MN 56267 Or ☐ Other _____
REQUESTOR Who should the information be sent to? (Name/Address)	☐ STEVENS COMMUNITY MEDICAL CENTER 400 East First Street, PO Box 660 Morris, MN 56267 Attn: _____ Or ☐ Other _____
PURPOSE OF INFORMATION RELEASE	☐ Continuation of Medical Care (**Date of Appointment**_____) ☐ Insurance Application ☐ Disability Determination ☐ Personal Records ☐ Payment of Insurance Claims ☐ Legal ☐ Other_____ ☐ Consult / second opinion ☐ Out of town move
INFORMATION SHOULD INCLUDE	☐ Clinic Chart Notes from _____ (date) to _____ (date) ☐ X-Ray Reports ☐ EKG Reports ☐ X-Ray films ☐ EEG Reports ☐ Lab Data_____ ☐ Discharge Summary ☐ Physicians IP Progress Notes ☐ History & Physical Exam ☐ Operative Reports ☐ Outpatient Notes ☐ Surgical Pathology Reports ☐ Other_____

1. Covering records for the period from _____(date) to_____(date)
2. Confined to the following specified information: _____

I understand that the information in my health record may include information related to alcohol or drug abuse, sickle cell anemia or psychological and/or psychiatric conditions and for testing and/or treatment of HIV, or AIDS and STD'S.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following, date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in one year. A photocopy of this authorization is as valid as the original form with my original signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Treatment will still be provided to me if I do not sign this form. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed.

Signature of person releasing information (Patient/Guardian)	Date signed	Witness
*Relationship to patient, if signed by other person	Reason patient unable to sign	

***If you are the legal responsible party acting on behalf of the patient, please provide legal documentation.**

This page is
for Office Use Only
Information Released

RECORDS RELEASED: _____
_____
_____

☐ Mailed ☐ Faxed ☐ Phoned ☐ In person to:_____

Date _____ Medical Records Personnel (Initial) _____

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RECORDS RELEASED: _____
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_____

☐ Mailed ☐ Faxed ☐ Phoned ☐ In person to:_____

Date _____ Medical Records Personnel (Initial) _____

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☐ Mailed ☐ Faxed ☐ Phoned ☐ In person to:_____

Date _____ Medical Records Personnel (Initial) _____

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