

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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|--|--|--------------------------------|
| Patient Identification | Name _____ Date of birth _____ Address _____ Phone _____ City/State/Zip _____ Maiden/previous names/nicknames _____ | |
| Provider (Who is releasing information?) | Sanford Luverne Medical Center 1600 N. Kniss Avenue Luverne, MN 56156-1067 | Other: _____ _____ _____ |
| Disclose information to: (Where is information to be sent?) | Name/facility _____ Address _____ City/State/Zip _____ Phone _____ Fax _____ | |
| Information to be disclosed: | <input type="checkbox"/> All records <input type="checkbox"/> EKG/Cardiology reports <input type="checkbox"/> Progress Notes <input type="checkbox"/> Radiology <input type="checkbox"/> Reports <input type="checkbox"/> ER Records <input type="checkbox"/> Lab Reports <input type="checkbox"/> History & Physical <input type="checkbox"/> Pathology Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Treatment for Drug or Alcohol Dependency <input type="checkbox"/> Operative Report <input type="checkbox"/> Cradle Roll <input type="checkbox"/> Other _____ | |
| Service Dates | Time period from: _____ to _____ Concerning : _____ (specific diagnosis or treatment, auto accident, etc.) | |
| Purpose of Disclosure | <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other (specify) _____ For marketing: The disclosing organization <input type="checkbox"/> will <input type="checkbox"/> will not receive compensation, monetary, or otherwise, as a result of this use or disclosure. | |
| Expiration Date | This authorization will expire one year from the date of signature. If this information is for a research study it will expire at the end of the research study. | |
| Revocation | I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted below. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself. | |
| Authorization | I hereby authorize the below facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled “Disclose Information To”. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits. _____ Signature of patient/representative Signature date _____ (Relationship to patient, if signed by representative) (Witness- optional) Please supply proof of authority to act. For minors, proof only required if other than parent. | |
| Disposition | For office use only: Date sent: _____ by: _____ <input type="checkbox"/> by mail <input type="checkbox"/> faxed <input type="checkbox"/> picked up MR#: _____ / _____ | |

SANFORD

Luverne

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sanfordluverne.org