

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME _____ **DATE OF BIRTH** _____
Last First MI

Home Phone: _____ Work: _____ Cell: _____

RELEASE TO: Mail <input type="checkbox"/> Pick Up <input type="checkbox"/> Name (of facility or person picking up) _____ Address _____ City/State/Zip _____	RELEASE FROM: Name _____ Address _____ City/State/Zip _____
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RECORDS TO BE RELEASED (*A current two years of records will be released for continuing care.)

- | | | | |
|--------------------------|---------------------|------------------------|-----------------------------|
| _____ Clinic Visit Notes | _____ X-ray Reports | _____ Specialist | _____ Entire Record |
| _____ Ob-Gyn | _____ X-ray Films | _____ Physical Therapy | _____ Workers' Compensation |
| _____ Lab Reports | _____ Hospital | _____ Physicals/Pre-op | _____ Prior Clinic |
- _____ Other: _____

**The following types of patient information will be released unless marked by an X below:

- Mental Health Psychotherapy HIV/Aids/STDS Chemical/Alcohol dependency

PURPOSE OF RELEASE

- _____ Change of Clinic _____ Specialty Consultation _____ Legal _____ Insurance
- _____ Other: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- This authorization will expire one year from date of signature or for a lesser period if specified here: _____
Initials _____.
- I may revoke this authorization at any time by providing notification in writing to Multicare Associates, and it will be effective on the date received except to the extent action has already been taken.
- There may be a charge incurred for copies of medical records pursuant to MN Statute 144.292 and Rule 164.524.
- A copy or faxed copy of this authorization will be treated in the same manner as the original.
- When Multicare Associates discloses PHI pursuant to this authorization, we can no longer guarantee confidentiality or prevent re-disclosure, and the information may no longer be protected by federal privacy rules.
- By signing this authorization, I agree to allow Multicare Associates and all their staff members to disclose the following PHI to the above stated persons(s) or entity.
- By signing this authorization I agree to all its contents and release Multicare Associates from any and all liability resulting from re-disclosure.
- I further understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

SIGNATURE (Patient or Legal Representative)
(AGE 18 OR OVER MUST SIGN FOR RELEASE OF THEIR RECORDS)

DATE

Parent Legal Representative
(ATTACH LEGAL DOCUMENT)