

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: (____) _____ City: _____ State _____ Zip _____
Clinic/Health Care Provider - (Who has the information you want released?) Please list the specific clinic.	NAME: _____ Address: _____ Day Phone: (____) _____ City: _____ State _____ Zip _____
Receiving Party (Where do you want the information sent?) Clinic, Specialist, _____	NAME: _____ Attention to: _____ Address: _____ Day Phone: (____) _____ City: _____ State _____ Zip _____ Fax Number (if records need to be faxed) (____) _____
Information to be Released (What do you want sent or released? Check the appropriate box.)	Records to be released (A current year of records will be released unless otherwise specified below. There is a fee for copying more than two years of records.) _____ <input type="checkbox"/> Routine records: This includes office visits, lab, radiology, medications and immunizations <input type="checkbox"/> Copies of films/images OR <input type="checkbox"/> Release all record types checked below: <input type="checkbox"/> Hospital <input type="checkbox"/> Radiology reports <input type="checkbox"/> OB/GYN <input type="checkbox"/> Medication records <input type="checkbox"/> History & physical exam <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Immunizations <input type="checkbox"/> Chemical dependency/ <input type="checkbox"/> Operative report <input type="checkbox"/> Mental health records <input type="checkbox"/> Pathology reports <input type="checkbox"/> Substance abuse records <input type="checkbox"/> Consultations <input type="checkbox"/> Progress notes/clinic notes <input type="checkbox"/> Other records - specify record type(s) _____ OPTIONAL Limits - Disclose only records related to the following: Date(s) of service: _____ Injury or illness: _____
Release Instructions (How and When do you want the information?)	Date information is needed: _____ (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING) <input type="checkbox"/> Mail <input type="checkbox"/> Pick up at Clinic
Purpose of Release (Why is it needed?)	<input type="checkbox"/> Continuing care <input type="checkbox"/> Transfer of care <input type="checkbox"/> Social Security appeal <input type="checkbox"/> Insurance application* <input type="checkbox"/> Personal use or review* <input type="checkbox"/> Social Security disability determination* <input type="checkbox"/> Insurance payment/claim <input type="checkbox"/> Litigation/legal* Other* _____ * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

ACKNOWLEDGEMENT OF UNDERSTANDING:

- This authorization will last for 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.
- 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)