AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PREMIER WOMEN'S HEALTH OF MINNESOTA

Name: _____ Date of Birth: _____
Previous Last Names: _____ Phone Number: _____
Address: _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____

REASON FOR DISCLOSURE (Choose only one option below)

❑Treatment/ Continuing Medical Care
❑Transfer of Care
❑Personal Use
❑Insurance
❑Billings or Claims
❑Legal Purposes
❑Referral
❑School
❑Employment
❑Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed.

❑All medical records, excluding Radiology Films
❑Records about specific condition: _____
❑Other (please specify): _____
❑Prenatal records
❑Operative report
❑Hospital records
❑Radiology reports
❑Visit notes
❑Immunization records
❑Laboratory reports

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

DATES OF INFORMATION TO BE RELEASED:

❑All clinic records
❑Last 6 months
❑Last 1 year
❑Last 2 years
❑Specific date of service: _____
❑Other (please specify): _____

FORMAT TO RECEIVE HEALTH INFORMATION:

❑Mail
❑Fax
❑Electronic Portal
❑Pickup by Patient
❑Pickup by Other (please specify name):_____
If Pickup by Other, please specify relationship to patient:_____

ID will be required to pick up records

Authorization Expiration Date or Event: _____
(If left blank, authorization will expire one year from date of signature)

Statement of Authorization

- I understand that I may revoke this authorization at any time with written notification to Medical Records, except to the extent that action has already been taken. A photocopy/fax/scanned image of this authorization will be treated in the same manner as an original.
- Premier Women's Health of Minnesota will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Representative Relationship to Patient Date