1805 Hennepin Ave N, Glencoe, MN 55336, Phone: 320-864-7993, Fax: 320-864-7998

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Date of Birth _____ MR# _____

Address _____

Email _____ Telephone _____ Provider _____

I hereby authorize Glencoe Regional Health Services to release the following medical information on the above listed patient to:

_____
Name/Organization

_____
Address City State ZIP Code

Phone #_____ Fax #_____

- ☐ Immunizations
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Laboratory Reports
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ EKG/EEG Reports
- ☐ Outpatient/ER Reports
- ☐ Radiology Reports
- ☐ Radiology Films
- ☐ Office Notes from _____ to _____
- ☐ Other (Specify) _____

For the following time period or condition: _____
(Specify dates or condition)

I am requesting this information for use by:

- ☐ Medical Personnel/Health Care Facility
- ☐ Attorney
- ☐ Other (Specify) _____
- ☐ Insurance Company
- ☐ Personal
- ☐ Law Enforcement

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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 one year from the date of my signature.

I understand that authorizing the disclosure of the health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand 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 entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

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

REQUIRED	**OPTIONAL**	**OFFICE USE ONLY**
Information needed: _____ Date _____ Time Method of Delivery ☐ Will Pick-Up ☐ Send Information ☐ Electronic ☐ MyChart	Per federal law the following information will not be released unless signed below. I specifically authorize the release of information relating to: ☐ Substance Abuse (alcohol/drug abuse) ☐ Mental Health (includes psychological testing) ☐ HIV-Related Information (AIDS related testing) _____ Signature of Patient/Guardian/Legal Representative _____ Date	☐ Entered in ROI Navigator ☐ Medical Imaging informed (if applicable) ☐ Information copied by and date _____ ☐ Patient picked up, please scan _____ (*initials*)