Authorization to Release Medical Information

Glencoe Regional Health, Attn: Health Information Management, 1805 Hennepin Ave. N., Glencoe, MN 55336-1416
Phone: 320-864-7993 **| Fax:** 320-864-7998 **| Email:** himroi@grhsonline.org

Patient's Full Name: _____ Date of Birth: _____

Address: _____ City:_____ State:_____ Zip: _____

Email: _____ Phone #: _____

SEND MEDICAL INFORMATION TO:

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

Name/Organization: _____

Address: _____ City:_____ State:_____ Zip: _____

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 - Dates:_____ to _____
- ☐ Other (Specify) _____

For the following dates or condition(s): _____

I am requesting this information for use by:

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

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 Signed

REQUIRED	OPTIONAL	OFFICE USE ONLY
Information needed by: Date: _____ Time: _____ ☐ Pick up at GRH ☐ Mail ☐ Fax ☐ Patient's Email ☐ 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 (includes alcohol/drug abuse) ☐ Mental Health (includes psychological testing) ☐ HIV-Related Information (includes AIDS-related testing) _____ Signature of Patient/Guardian/Legal Rep. Date Signed	MR#: _____ ☐ Entered in ROI Navigator ☐ Inform Medical Imaging *(if applicable)* ☐ Info. copied (*initials, date*) _____ ☐ Picked up, scan to chart _____ (*initials*)

PRINT