# Authorization to Transfer Medical Information to Glencoe Regional Health

**Medical Information Coming From:**

Facility Name: _____

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

Phone #: _____ Fax #: _____

For the purpose of continuing medical care, I hereby authorize and request you to send the following information to:

**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@glencoehealth.org

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

Email: _____ Phone #: _____

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

- ☐ Office Notes — Dates between _____ to _____
- ☐ Laboratory Reports — Dates between _____ to _____
- ☐ Radiology Reports — Dates between _____ to _____
- ☐ Radiology Films — Dates between _____ to _____

Per federal law, the following information will not be released unless signed below. I specifically authorize the release of information relating to:

- ☐ HIV-Related Information (including AIDS-related testing)
- ☐ Substance Abuse (alcohol/drug abuse)
- ☐ Mental Health (includes psychological testing)

_____

Signature of Patient/Guardian/Legal Representative Date

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

**GRH Office Staff Only:**

MR#: _____