DULUTH FAMILY MEDICINE CLINIC

330 North Eighth Avenue East , Duluth, MN 55805 218/723-1112 218/529-9120 *fax*

Authorization for Disclosure of Health Information

PLEASE PRINT

_____ _____
Patient Name/Previous Names Street Address

_____ _____ _____
Date of Birth Phone Number City, State, Zip

I HEREBY AUTHORIZE:

_____ _____ _____
Physician and /or Facility Street Address City/State/Zip

TO: ☐ Release confidential **written** information to: ☐Exchange confidential **verbal** information with:

_____ _____ _____
Physician / Facility/Other Street Address City/State/Zip

PURPOSE(S) OF THIS DISCLOSURE:

☐ Transfer to another Clinic ☐ Insurance
☐ Continued Care ☐ Personal Use
☐ Litigation/Attorney Use ☐Other_____

DATES OF INFORMATION TO BE RELEASED:

☐ All Dates
☐ From _____/_____/_____ to _____/_____/_____

SPECIFIC INFORMATION TO BE RELEASED:

☐ Any and all Medical Records
☐ Immunization Records
☐ Physician Office Notes
☐ History and Physical
☐ Medical Records regarding treatment for_____
(Specific Medical Condition or Injury)
☐ Other:_____

☐ Correspondence
☐ X-ray Reports
☐ Lab Test Results
☐ Other Test Results (Specify)_____

ALL RECORDS PERTAINING TO MENTAL HEALTH, ALCOHOL ABUSE, DRUG ABUSE, HIV, AIDS OR AIDS RELATED DISEASE, AND SICKLE CELL ANEMIA WILL BE RELEASED UNLESS OTHERWISE INDICATED HERE IN WRITING:_____

REDISCLOSURE NOTICE: I understand that the information disclosed through this authorization may be redisclosed by the recipient and/or may be no longer protected by federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to receive a copy of the health information to be used or disclosed-I understand that I have the right to receive a copy of the health information I have authorized to be used or disclosed by this authorization form.

Right to receive a copy of this authorization - I understand that I will receive a copy of this authorization form upon my request.

Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form. Treatment, payment, enrollment in a health plan, or eligibility to obtain health care benefits cannot be denied based on my refusal to sign this authorization. (Exceptions: Certain care is done solely for the purpose of creating information to release to another party. In these cases, care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for services provided.

Right to revoke this authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Health Information Services Department. I am aware that my withdrawal will not affect releases of information that have already occurred subsequent to this authorization.

Expiration Date: This authorization is good until the following date(s)_____ or for one year from the date signed.

I have reviewed and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative_____ **Date**_____

If signed by someone other than patient, state relationship and authority to sign:

☐ Parent ☐ Guardian ☐POA for HealthCare ☐ Parent or Spouse of deceased patient (specify relationship to patient)