AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NORTHFIELD HOSPITAL & CLINICS

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FamilyHealth Medical Clinics

Patient's name: _____ **Date of birth:** _____

This will authorize:

- ❑ FamilyHealth Medical Clinic - Farmington
  4645 Knutsen Drive, Farmington, MN 55024-8455
  Phone: (651) 460-2300 • Fax: (651) 460-2301
- ❑ FamilyHealth Medical Clinic - Lakeville
  9974 214th St. W., Lakeville, MN 55044-1914
  Phone: (952) 469-0500 • Fax: (952) 469-0505
- ❑ FamilyHealth Medical Clinic - Northfield
  2000 North Avenue, Northfield, MN 55057-1697
  Phone: (507) 646-1494 • Fax: (507) 646-6870
- ❑ FamilyHealth Medical Clinic - Lonsdale
  103 - 15th Avenue, S.E., Lonsdale, MN 55046-5001
  Phone: (507) 744-3245 • Fax: (507) 744-3247
- ❑ Orthopaedic and Fracture Clinic of Northfield
  1381 Jefferson Road, Northfield, MN 55057-3080
  Phone: (507) 646-8900 • Fax: (507) 646-8904
- ❑ Women's Health Center of Northfield Hospital
  2000 North Avenue, Northfield, MN 55057-1697
  Phone: (507) 646-1478 • Fax: (507) 646-6870

To release copies of the following information:

- ❑ Discharge Summaries
- ❑ Operative Reports
- ❑ Pathology Reports
- ❑ History and Physical
- ❑ Lab Data, including: _____
  _____
- ❑ Outpatient Reports
- ❑ X-ray Reports
- ❑ E.K.G. Reports
- ❑ Consultation Reports
- ❑ Immunization Records
- ❑ Office Visit Notes
- ❑ **Entire Medical Chart**
- ❑ Other, including: _____
  _____
  _____
  _____

Purpose of disclosure: Treatment or Other _____

Special Authorization *(Check the applicable box[es] and sign below.)*

By signing below, I am authorizing the office to release any and all information regarding:

❑ Alcohol ❑ HIV ❑ Mental Health
❑ Drugs ❑ AIDS ❑ Sexually Transmitted Diseases

Note — If this release pertains to alcohol, drugs, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please send records to:

Name of clinic: _____

Address: _____

City: _____

State: _____ **Zip code:** _____

I give permission to the PROVIDER to release Medical Record Information to the above-named physician, facility, or person named above. The information released will be restricted by any INFORMATION LIMITATIONS outlined above, and may be used only for the purposes described.

I understand that this release will take effect on the date signed and will be in effect for one year.

I understand that I can cancel this release at any time by notifying the PROVIDER in writing that my cancellation will take effect when the PROVIDER receives my written notice. I understand that my cancellation will not have any effect on information released before the PROVIDER received my written notice. Health information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I understand that I am entitled to receive a copy of this authorization.

We will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization OR we will describe the consequences of refusal to sign an authorization.

_____ _____
Signature of patient/parent/guardian *Date*

_____ _____
Relationship to patient *Reason that patient is unable to sign*