ID# _____ Ridgeview MEDICAL CENTER MR# _____

Authorization for Disclosure of Protected Health Information

Name: **Birthdate:**

Address: **Phone #:**

City/State/Zip:

*****All bold areas must be complete to be a valid Release!**

Requesting Information from:

Ridgeview Medical Center -- Medical Records
500 South Maple St. Fax: 952-442-6538 Attn: ROI
Waconia, MN 55387 Phone: 952-442-2191, ext. 5139

Send Information to:

[ ] Pick up [ ] Self
Name/ Facility: [ ] Mail [ ] Parent
Address: [ ] Email [ ] POA/ Next of Kin
City/State/Zip [ ] Fax [ ] Other
Phone: Fax: E-mail:

Records can *NOT* be faxed to a personal / work fax machine!!

Information to be Released:

[ ] ANY AND ALL RECORDS (INCLUDES ALL TYPES OF RECORDS LISTED BELOW)

[ ] H&P / Consult / ER
[ ] Operative Report/ Pathology
[ ] Progress Notes
[ ] Discharge Summary
[ ] Physical Therapy Records
[ ] Pathology Slides
[ ] Radiology Film
[ ] Radiology / Lab Report
[ ] Itemized Bills
[ ] Other _____

***All information regarding alcohol/ drug use or abuse, mental health and/ or HIV or AIDS *WILL BE RELEASED* unless you tell us not to by initialing below:**

_____Do Not Release Alcohol/Drug Use or Abuse records
_____Do Not Release Mental Health records
_____Do Not Release HIV/AIDS records

Limit Records to Specific Dates / Diagnosis / Treatments of: _____
****Records may be limited to last 2 years, continued care will ONLY be last 2 years.**

Purpose of Disclosure:

[ ] At the Request of the Patient
[ ] Transfer of Records to New Physicians or Consult
[ ] Legal
[ ] Research Purposes
[ ] Insurance Claim / Life Insurance

This authorization will expire one year from the date of signature or on:_____

I understand that I may revoke this authorization at any time by sending written notice to the health care facility / provider noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.

I hereby authorize the above facility / provider to disclose medical information concerning the above named patient to the party identified as the send information to party. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, also HIV related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Signature of Patient or Representative **Date**

****If signed by a representative, please state authority to act on behalf of the patient****

A photo copy/fax of this authorization will be treated in the same manner as an original.

For office use only.

[ ] Mailed [ ] Faxed [ ] Emailed [ ] Patient Pickup

[ ] Identification Checked [ ] POA Verified Completed by(initials)_____Date:_____