MINISTRY HEALTH CARE

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient/Previous Names _____ Birth Date/Medical Record Number _____

Street Address _____ City, State, Zip, Phone Number _____

AUTHORIZES DISCLOSURE BY:

□ **St. Elizabeth's Medical Center; Wabasha MN**

Or By:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

DISCLOSURE OF HEALTH INFORMATION TO:

□ **St. Elizabeth's Medical Center; Wabasha, MN**

Or To:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*

- ❑ Discharge Summary
- ❑ Pathology Report
- ❑ ED Report
- ❑ History & Physical
- ❑ Radiology Report-Films
- ❑ Other: _____
- ❑ Consultation
- ❑ Laboratory Report
- ❑ Operative Report
- ❑ Rehab Notes

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Minnesota Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

- ❑ HIV/AIDS Virus*
- ❑ Mental/Behavioral Health Conditions
- ❑ Drug/Alcohol Abuse/Treatment

FOR THE FOLLOWING DATES: From: _____ To _____

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

- ❑ Continuing Care
- ❑ Disability Determination
- ❑ Other: _____
- ❑ Personal Use
- ❑ Vocational Rehab Eval
- ❑ Insurance/Claim Purposes
- ❑ Legal Investigation
- ❑ Workers Compensation

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment,** enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization –** I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to St. Elizabeth's Medical Center. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. St. Elizabeth's Medical Center will not condition treatment, payment, enrollment or eligibility of benefits on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

EXPIRATION DATE: This authorization is good until the following date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP.: _____ **DATE:** _____
(If signed by other than patient, state relationship and authority to do so.)

FOR ORGANIZATION'S USE				
Date Received:	Date Disclosed:	❑ Mailed	❑ Faxed	❑ Picked Up By: