Madelia HEALTH

Authorization for Disclosure of Personal Health Information

Patient Identification	Name:_____ Date of Birth:_____ Address:_____ Phone Number_____ City/State/Zip:_____ Maiden/Previous Names/Nickname:_____
Provider (Who is releasing Information?)	Provider/Facility Name:_____Madelia Health_____ Address:_____121 Drew Ave. SE_____ City/State/Zip:_____Madelia, MN 56062_____ Phone Number:____507-642-3255_____Fax: 507-642-8010_____
Disclose Information To: (Where is information to be sent?)	Name/Facility:_____ Address:_____ City/State/Zip:_____ Phone Number:_____ Fax:_____
Information to be Disclosed	☐ Hospital Progress Notes ☐ History & Physical ☐ Pathology Report ☐ EKG/Cardiology Reports ☐ Discharge Summary ☐ Physical Therapy Notes ☐ Radiology Reports ☐ Operative Report ☐ Outpatient Information ☐ ER Records ☐ Lab Data ☐ Consultation ☐ All Records ☐ Other (Specify)_____
Service Dates	Time period from:_____ to _____ Concerning:_____ (specific diagnosis or treatment, auto accident, etc.)
Purpose of Disclosure	☐ Continuing Medical Care ☐ Consult/Second Opinion ☐ Out of town move ☐ Insurance Claim ☐ Legal ☐ Personal ☐ Other (Specify)_____
Expiration Date	This authorization will expire one year from the date of signature or on_____.
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.
Authorization	I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To", I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and 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 understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits. _____ _____ Signature of patient/representative Signature Date _____ _____ _____ (Relationship to patient, if signed by representative) (Reason patient unable to sign) (Witness – optional) Please supply proof of authority to act. For minors, proof only required if other than parent.
Internal Use Only:	Info needed by:_____ Date sent:_____ Sent by:_____ ☐ Authority to act attached ☐ ID Validated Records to be: ☐ Mailed ☐ Will pick up Need to call pt when ready? ☐ Yes ☐ No Phone #: _____