



1000 East First Street, Suite 400
 Duluth, MN 55805
 Phone: 218-722-5513, Fax: 218-625-2757

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

Patient Name: LAST FIRST MI

Date of Birth Medical Record Number

I hereby authorize:
 (Name and address of releasing facility)

To Release Information to:
 (Individual name, facility/organization, and address)

PURPOSE OF DISCLOSURE

- Continuing Care
- Payment of Claim
- School
- Worker's Compensation
- Legal
- For Personal Use
- Other (specify): _____

I specifically authorize the release of information relating to:
 Substance abuse (including alcohol/drug use)
 Behavioral Health
 HIV related information (AIDS related testing)

 Signature of Patient or Personal Representative Date

INFORMATION TO BE RELEASED

Between Dates of:

Between Dates of:

- Discharge Summary _____
- H&P Exam/Initial Evaluation _____
- Consult _____
- Counselor/Therapist Summary _____
- Progress Notes/Provider Notes _____
- Others _____
- Other (specify content and dates): _____
- Only Record of Doctor _____

- X-ray Reports _____
- X-Ray Films/MRI _____
- Diagnostic Test Reports _____
- Procedure Reports _____
- Lab Reports/Pathology _____
- Correspondence _____

ACKNOWLEDGEMENT OF UNDERSTANDING

- I understand the expiration date of this authorization is 1 year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

 Signature of patient, parent of minor, or personal representative

 Relationship

 Date