AUTHORIZATION TO VERBALLY RELEASE MEDICAL RECORDS OF PROTECTED HEALTH INFORMATION SPECIAL CIRCUMSTANCES

For PRHHS staff use only
Chart/MR #: _____
Released by: _____
Date Released: _____

Circle Primary Place of Service

Elbow Lake
1411 Highway 79 E
Elbow Lake, MN 56531
(P) 218-685-7300
(F) 218-685-7291
(P) 218-685-7380 (Therapy)
(F) 218-685-7294 (Therapy)

Evansville
649 ½ State Street
Evansville, MN 56326
(P) 218-948-2040
(F) 218-948-2051

Ashby
110 County Road 82
PO Box 167
Ashby, MN 56309
(P) 218-747-2293
(F) 218-747-2294

Hoffman
114 Main Avenue
PO Box 277
Hoffman, MN 56339
(P) 320-986-2038
(F) 320-986-2041

Morris
24 E 7th Street
PO Box 410
Morris, MN 56267
(P) 320-589-4008
(F) 320-589-4227

Herman
204 5th Street
Herman, MN 56248
(P) 320-677-2221
(F) 320-677-2221

Patient Phone Number: _____

I, _____
Last Name *First Name* *Middle Int.* *Maiden Name*

Date of Birth: _____ Last 4 digits of Social Security Number: XXX-XX-_____

***I HEREBY AUTHORIZE:**
Name of Physician/HealthCare Facility:

_____
Street Address: _____
City/State/Zip Code: _____
Phone #: _____

***TO RELEASE TO:**
Name of Physician/HealthCare/Other:

_____
Street Address: _____
City/State/Zip Code: _____
Phone #: _____

***TYPE OF INFORMATION TO BE RELEASED:**
( ) Authorization for individual above to have access to my billing information
( ) Consent for Medical Information/Test Results, verbal, to individual listed above
( ) Consent for verbal communication between my PRHHS provider and the individual listed above

***RECORDS FROM THE TIME PERIOD:**
*Specify date (s):_____ to: _____ ( ) All Records

***IN COMPLIANCE WITH FEDERAL AND STATE LAWS:**
In compliance with Federal State laws which require special permission to release otherwise privileged information, please release records pertaining to:
( ) Alcoholism ( ) Mental Health ( ) HIV test results, AIDS, or AIDS-related disease
( ) Drug abuse ( ) Developmental Disabilities ( ) Not Applicable

***PURPOSE OR NEED FOR DISCLOSURE:**
( ) By Patient Request ( ) Other: _____

I authorize release of my medical records in accordance with the specifications listed above. I understand that this authorization shall be valid for 1 year unless otherwise stated above or revoked through written notice to medical records. Photocopies of the authorization will be accepted in lieu of the original.

*Signature: _____ Date: _____
Patient (Parent or Guardian if under 18)
*Witness: _____ Date: _____
Relationship to Patient

PRHHS cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release PRHHS from any and all liability, resulting from a redisclosure by the recipient.

Person authorized by the patient means the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient or any person authorized in writing by the patient. A court appointed temporary guardian may also qualify to consent to the release of records.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIM department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoke, this authorization will expire on the following date, event or condition. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524.