Authorization for Release of Information

Please Return This Form When Sending Records

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

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

Date of Birth: _____ Patient Phone Number: _____

Hereby authorize records release from:

_____
_____
_____

Where should this information be sent:

_____
_____
_____

Type of information to be released:

IMPORTANT: indicate only the information that you are authorizing to be released

( ) All/any medical information present in my medical record (Last 3 years, unless otherwise specified)
( ) Service Date(s): _____
( ) Physician Notes ( ) X-ray Reports ( ) Diagnostic Test Reports
( ) Laboratory Reports ( ) X-ray Images ( ) Immunization Records
( ) Pathology ( ) EKG ( ) Itemized Statements
( ) Other (specify) _____

The following information requires special consent by law. Even if you indicate all health information you must specifically request the following information in order for it to be released. (If it applies)

( ) Chemical dependency program Records ( ) Mental Health Records
( ) Psychotherapy notes ( ) HIV/AIDS Records

The information is needed for the purpose of:

( ) Transfer of medical care ( ) Insurance
( ) Legal ( ) Personal
( ) Other (please specify) _____

I understand that I may revoke this consent at any time in writing. Revocation will not apply to information already released. This authorization expires one year from the date signed or _____ (Date) or once this authorization has been fulfilled. I do not authorize re-release of chemical dependency, mental health and HIV status related information by the party receiving it. ***A photocopy shall be as valid as the original.***

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.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim or (4) creating health information to provide to a third party.

_____ Date: _____
Patient signature (Parent or Guardian if under 18)

_____ Date: _____
Relationship to Patient (May require legal documentation)