



Clinic     Hospital  
Authorization for Release of Information

Patient Name: \_\_\_\_\_

Mailing Address \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Maiden/Other Name: \_\_\_\_\_

I Authorize:     CHI LakeWood Health  
 Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To release Protected Health information (PHI) to:     Myself     CHI LakeWood Health  
 Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Method of release:     To be sent by HIM dept.     To be picked up: \_\_\_\_\_     Was given when signed  
Date & Location

**Information to be released:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Operative reports | <input type="checkbox"/> X-ray reports: are films needed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Discharge summary         | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Physical/Occupational Therapy notes   |
| <input type="checkbox"/> Consultation reports      | <input type="checkbox"/> EKG reports       | <input type="checkbox"/> Face Sheet with final diagnoses, procedures   |
| <input type="checkbox"/> Laboratory reports        | <input type="checkbox"/> EEG report        | <input type="checkbox"/> Emergency Room record   |
| <input type="checkbox"/> Other (specify): _____    |  |  |

Dates of information to be released:     One year prior     Other: \_\_\_\_\_

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

This release is valid for one year from the date of signature unless specified: \_\_\_\_\_

**Reason for the Use or Disclosure**

- Further Treatment     Insurance     Legal     Personal Records     Marketing\*\*\*     Other \_\_\_\_\_

**Prohibition on Conditioning of Authorization:** LakeWood Health Center will not condition treatment on your signing this authorization, unless you are receiving research-related treatment, or the only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical). \*\*\*If authorization is for **marketing**, will CHI LakeWood Health receive compensation for disclosure of PHI?     Yes     No

**Re-disclosure:** I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

**Revocation:** I understand that I may revoke this authorization at any time by notifying LakeWood Health Center in writing by sending a letter to: Medical Records Department, LakeWood Health Center, 600 Main Avenue South, Baudette, MN, 56623, or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that LakeWood Health Center took before it received my revocation letter. For example, LakeWood Health Center cannot withdraw disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

**This authorization is binding:** The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in LakeWood Health Center's Notice of Privacy Practices. Photocopy valid as original.

\_\_\_\_\_  
 Signature of patient Date

\_\_\_\_\_  
 Signature of personal representative    Print Name    Relationship (e.g, mother, legal guardian)    Date