CHI LakeWood Health

☐ 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:

☐ History and physical exam ☐ Operative reports ☐ X-ray reports: are films needed? ☐ Yes ☐ No
☐ Discharge summary ☐ Pathology reports ☐ Physical/Occupational Therapy notes
☐ Consultation reports ☐ EKG reports ☐ Face Sheet with final diagnoses, procedures
☐ Laboratory reports ☐ EEG report ☐ Emergency Room record
☐ 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