

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

 Name of Patient/Previous Names

 Birth Date/Medical Record Number

 Street Address

 City, State, Zip, Phone Number

AUTHORIZES DISCLOSURE BY:
 St. Elizabeth's Medical Center; Wabasha MN
DISCLOSURE OF HEALTH INFORMATION TO:
 St. Elizabeth's Medical Center; Wabasha, MN

Or By:

Or To:

 Name of Health Care Provider/Plan/Other

 Name of Health Care Provider/Plan/Other

 Street Address

 Street Address

 City, State, Zip Code

 City, State, Zip Code

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Radiology Report-Films | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Rehab Notes |
| <input type="checkbox"/> ED Report | <input type="checkbox"/> Other: _____ | | |

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Minnesota Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV/AIDS Virus* | <input type="checkbox"/> Mental/Behavioral Health Conditions | <input type="checkbox"/> Drug/Alcohol Abuse/Treatment |
|--|--|---|

FOR THE FOLLOWING DATES: From: _____ To: _____

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Insurance/Claim | <input type="checkbox"/> Legal Investigation |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Vocational Rehab Eval | <input type="checkbox"/> Purposes | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> Other: _____ | | | |

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment,** enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to **St. Elizabeth's Medical Center**. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. St. Elizabeth's Medical Center will not condition treatment, payment, enrollment or eligibility of benefits on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP.: _____ **DATE:** _____
(If signed by other than patient, state relationship and authority to do so.)

FOR ORGANIZATION'S USE				
Date Received:	Date Disclosed:	<input type="checkbox"/> Mailed	<input type="checkbox"/> Faxed	<input type="checkbox"/> Picked Up By: