

**AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION**

<b>PATIENT INFORMATION</b>	NAME: _____ DATE OF BIRTH: _____ ADDRESS: _____ DAY PHONE: _____ CITY: _____ STATE: _____ ZIP: _____
<b>FORWARDING CLINIC/PROVIDER/HOSPITAL</b>	PROVIDER NAME: _____ CLINIC NAME: _____ FAX: _____
<b>SENDING THE INFORMATION</b>	ADDRESS: _____ PHONE: _____ CITY: _____ STATE: _____ ZIP: _____
<b>RECEIVING PARTY</b>	PROVIDER NAME: _____ ATTN: _____ CLINIC NAME: _____ FAX: _____ ADDRESS: _____ PHONE: _____ CITY: _____ STATE: _____ ZIP: _____
<b>WHERE INFORMATION GOES</b>	
<b>INFORMATION TO BE RELEASED</b>	<input type="checkbox"/> OFFICE VISITS DATES: _____ <input type="checkbox"/> BILLING RECORDS DATES: _____ <input type="checkbox"/> ANY AND ALL RECORDS (INCLUDES ALL RECORDS LISTED BELOW) <input type="checkbox"/> DISCHARGE SUMMARY <input type="checkbox"/> RADIOLOGY REPORTS <input type="checkbox"/> EMERGENCY RECORDS <input type="checkbox"/> MEDICATION RECORDS <input type="checkbox"/> HISTORY & PHYSICAL EXAM <input type="checkbox"/> REHAB RECORDS (PT/OT/ST) <input type="checkbox"/> IMMUNIZATION/ALLERGY RECORD <input type="checkbox"/> CHEMICAL DEPENDENCY/SUBSTANCE ABUSE <input type="checkbox"/> OPERATIVE REPORT <input type="checkbox"/> LABORATORY REPORTS <input type="checkbox"/> PATHOLOGY REPORTS <input type="checkbox"/> PATHOLOGY SLIDES/BLOCKS <input type="checkbox"/> CONSULTATIONS <input type="checkbox"/> PROGRESS NOTES/CLINIC NOTES <input type="checkbox"/> MENTAL HEALTH RECORDS <input type="checkbox"/> OTHER (SPECIFY) _____ OPTIONAL LIMITS: RECORDS RELATED ONLY TO FOLLOWING: DATE(S) OF SERVICE: _____ INJURY OR ILLNESS: _____
<b>WHAT DO YOU WANT SENT OR RELEASED?</b>	
<b>RELEASE INSTRUCTIONS</b>	DATE INFORMATION IS NEEDED: _____ (NOTE: PLEASE ALLOW 7 – 10 DAYS FOR PROCESSING)
<b>WHEN DO YOU WANT THE INFORMATION?</b>	
<b>PURPOSE OF RELEASE</b>	<input type="checkbox"/> CONTINUING CARE <input type="checkbox"/> TRANSFER OF CARE <input type="checkbox"/> SOCIAL SECURITY APPEAL <input type="checkbox"/> INSURANCE APPLICATION * <input type="checkbox"/> PERSONAL USE* <input type="checkbox"/> SOCIAL SECURITY DISABILITY DETERMINATION* <input type="checkbox"/> INSURANCE PAYMENT/CLAIM <input type="checkbox"/> LITIGATION/LEGAL* <input type="checkbox"/> OTHER*: _____
<b>WHY IS IT NEEDED?</b>	A <b>\$20.00</b> FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.292 AND FEDERAL RULE 45 C.F.R. §164.524

\*This authorization lasts for one year after the date you sign it unless you enter a different date or expiration date here: \_\_\_\_\_

\*This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.

\*MNCOME will not restrict my treatment if I choose not to sign this authorization

\*A photocopy/fax of this authorization will be treated in the same way as an original

\*MNCOME's records may include records that it received from other organizations. If these records have been used by MNCOME and filed in the record MNCOME maintains about you, these records may be released with your MNCOME records

\*MNCOME 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 general privacy protections after it is released. By signing this authorization, you release MNCOME from any and all liability resulting from a redisclosure by the recipient.

\*Your signature indicates that you have read and understand this form, and authorize release of your information as described.

 \_\_\_\_\_  
 PATIENT/LEGAL GUARDIAN SIGNATURE

 \_\_\_\_\_  
 DATE

 \_\_\_\_\_  
 AUTHORITY TO ACT ON BEHALF OF PATIENT  
 (ATTACH DOCUMENT)