Authorization for Disclosure of Protected Health Information - CLINIC

Print patient's legal name _____ Previous Names _____

Address, City, State Zip _____ Birth date _____/_____/_____

Phone numbers (Home) _____-_____-_____ (Work) _____-_____-_____ (Other) _____-_____-_____

This form, when completed and signed, authorizes the parties below to release and/or exchange protected information from records.

I authorize: **WESTERN OB/GYN**
A Division of Ridgeview Clinics
560 S. Maple Street Suite 130
Waconia, MN 55387
Fax (952) 856-4090 | Phone: (952) 856-4031 | Email: westernob@ridgeviewmedical.org

To release ☐ **TO** ☐ **RECEIVE FROM** the following party:

Person, clinic or organization: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone: _____-_____-_____ Fax: _____-_____-_____

To release and/exchange the following information: ☐ Any and all records (includes all types of records listed below):

☐ Progress Notes ☐ Itemized Bills ☐ Lab/Pathology Reports ☐ Consult Reports by Dr. _____

☐ Radiology Films/Images ☐ Radiology Reports ☐ Pre-Employment Records ☐ hospital/medical center reports

☐ Other: _____

For condition or dates of treatment: _____ (*If blank, we will release 1 years' worth of most recent records.*)

I would like to receive my records by: ☐ I will pick up ☐ Mail ☐ Email _____

I understand the following:

Except for psychotherapy notes (which are not included in my medical record), all records of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV will be released. If I don't want these to be released, I will place a checkmark here: _____. I DO NOT want the following records released:

☐ Alcohol/Drug Use or Abuse Records ☐ Mental Health Records ☐ AIDS/HIV Records ☐ Sickle Cell ☐ Genetic Conditions

Purpose of Disclosure:

☐ Continued care by another provider ☐ Insurance claim ☐ Personal use ☐ Transfer of Care ☐ Moving

☐ Coordination of Services ☐ Legal ☐ Other _____

If releasing records to yourself, should the envelope be marked "Personal and Confidential"? ☐Yes ☐No

This form expires one year after I sign it or sooner (specify here: _____). The time period noted here may exceed one year in certain situations specified by law.

I understand that I may revoke this authorization at any time by sending written notice to the health facilities noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy. Once the records are released, Ridgeview Medical Center cannot prevent them from being released to a third party. At that point, the records may no longer be protected by state and federal privacy laws.

I hereby authorize the above facilities to disclose medical information concerning the above named patient. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, also HIV related information. I understand that once information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____ _____

Date **Signature of client or authorized person** **Authorized person's authority to sign**

Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ other: _____

To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
Office Use: ☐ Mailed ☐ Faxed ☐ Patient Pickup ☐ Email | ☐ Identification Verified Initials _____ Date: _____