

AUTHORIZATION FOR RELEASE OF INFORMATION

Waseca Medical Center

501 N. State Street, Waseca, MN 56093

Mayo Health System

Phone: 507-835-1210 Fax: 507- _____

Patient:	Name (Last) _____ (First) _____ (Middle) _____	Previous Name _____
	Address _____	Day Phone # _____
	City _____ State _____	Zip _____
	Date of Birth _____ Social Security # (Optional) _____	Medical Record # _____

INFORMATION TO BE DISCLOSED: Clinic Hospital Mail Pickup Appointment Date _____

HEREBY AUTHORIZE: (Name & Address of Releasing Facility)

TO DISCLOSE MEDICAL INFORMATION TO: (Name & Address) _____

Immanuel St. Joseph's Hospital Springfield Medical Center

ISJ Clinic — EastRidge ISJ Clinic — NorthRidge

Parkview Clinic Madelia Clinic ISJ Specialty Clinic

Le Sueur Clinic St. Peter Clinic St. James Medical Center

Waseca Medical Center Other _____

Information to be disclosed: Information as identified below (check all that apply) relating to (illness/injury) _____ compiled during (visit date) _____

Progress Sheets/Clinic Notes

Emergency Room Report

Cardiac Rehab

Doctors Orders

Operative Report

Pulmonary Rehab

Lab

Pathology Report

Occupational Health

X-ray Reports

Physical Therapy

Psychological Report

Films

Occupational Therapy

Chemical Dependency

Discharge Summary

Speech Therapy

View Medical Record

History & Physical

Mental/Behavioral Health Notes

Other _____

All records pertaining to psychiatric/mental health, chemical dependency and/or communicable disease (AIDS, etc. if any such information exists) may be released unless otherwise specified here:

PURPOSE FOR DISCLOSURE:

Continuation of Medical Care

Payment of Claim

Litigation

Worker's Compensation

Other (please specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

As stated in the Notice of Privacy, I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Department.

(Signature of Patient)

(Date)

If patient is not able to sign, please indicate relationship to patient:

Parent of Minor

Legal Guardian

Healthcare Power of Attorney

Other

ID Verification _____ Completed By _____ Date _____
(Type) (Initials)