AUTHORIZATION FOR RELEASE OF INFORMATION

Springfield Medical Center
Mayo Health System
625 North Jackson Avenue, Springfield, MN 56087
Phone: 507-723-6201 Fax: 507-723-6447

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)*

❑ 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 ________________

TO DISCLOSE MEDICAL INFORMATION TO: *(Name & Address)* ________________

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 confidentially 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)*