PHONE: 507-831-2400
FAX: 507-831-5749

WINDOM AREA HEALTH
2150 HOSPITAL DRIVE
WINDOM, MN 56101

WINDOM AREA HEALTH

Authorization for Disclosure of Personal Health Information

Patient Identification

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City/State/Zip: _____

Maiden/Previous Names/Nickname: _____

Patient Social Security Number: _____

Provider
(Who is releasing information?)

Provider/Facility Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Disclose Information To:

Name/Facility: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Fax: _____

Information to be Disclosed

☐ Clinic Progress Notes
___ Physician's
___ Nurse's
___ Other
☐ Hospital Progress Notes
___ Physician's
___ Nurse's
___ Other
☐ EKG / Cardiology Reports
☐ Radiology Reports
☐ ER Records
☐ History & Physical
☐ Discharge Summary
☐ Operative Report
☐ Immunization Record
☐ Treatment for Drug or Alcohol Dependency
☐ Lab Data
☐ Pathology Report
☐ Psychiatric Evaluation
☐ Outpatient Information
☐ Consultation
☐ All Records
☐ Clinical Assessment
☐ Other (Specify) _____

Service Dates

Time period from: _____ to _____
Concerning: _____
(specific diagnosis or treatment, auto accident, etc.)

Purpose of Disclosure

☐Continuing Medical Care
☐Insurance Claim
☐Other (Specify) _____
☐Consult / Second Opinion
☐Legal
☐Out of town move
☐Personal

Expiration Date

This authorization will expire one year from the date of signature or on _____.

Revocation

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Authorization

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that the record may include provider records from other facilities or providers of care. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

_____ _____
Signature of patient/representative Signature Date

_____ _____ _____
(Relationship to patient, if signed by representative) (Reason patient unable to sign) (Witness – optional)

Please supply proof of authority to act. For minors, proof only required if other than parent.

Internal Use Only:

MR #: _____
Authorization Received: _____ (date)

Disposition
Info needed by: _____
Date released: _____
Released by _____

☐ Authority to act attached
☐ ID Validated