CENTRACARE
Family Health Center

Authorization for Release of Health Information

Please Print

1555 Northway Dr, Suite 200
St Cloud MN 56303-1413
Phone Number: (320) 240-3157
Fax Number: (320) 240-3164

Note: All items on this form must be completed to insure prompt release of information. If the form is incomplete, it will be returned and no information will be released until it is promptly completed. The date of signature must not pre-date treatment.

Patient	Name		Date of Birth
	Address		Phone Number
	City	State	Zip Code
	Previous Name		
Clinic/Hospital **Who has information you would like to be released:**	☐ CentraCare Family Health Center; 1555 Northway Dr, Suite 200; St Cloud MN 56303-4913		
	Name		
	Address		Phone Number
	City	State	Zip Code
Requesting Party **Send information to:**	☐ CentraCare Family Health Center; 1555 Northway Dr, Suite 200; St Cloud MN 56303-4913		
	Name		
	Address		Phone Number
	City	State	Zip Code

Information to Be Disclosed
Only the information check marked will be released

Date(s) of service or types of service to be released: From:_____To :_____

___Progress Notes	___Laboratory Reports	___Other (please specify)
___Procedure Notes	___Radiology Films	_____
___Diagnostic Test Reports	___Radiology Reports	_____
___Pathology Reports	___All	_____
___Consult Reports		

Special Disclosures

___Chemical Dependency ___Psychiatric ___HIV
_____to _____Concerning:_____
Date Date Specific diagnosis or treatment

Revocation

This authorization will remain in effect for a maximum of 1 year from the date of signature and may be cancelled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

Reason for Disclosure

___Continuation of Care ___Personal Use ___Attorney ___Insurance ___Other (specify)

Authorization
(I authorize the above provider to release the information marked above to the requester)

Patient/Guardian Signature Date

/ /

Relationship to Patient Reason Patient is Unable to Sign

CentraCare will not refuse treatment to any patient that refuses to sign an authorization for release of Protected Health Information. Once released, the information will no longer be covered under the Federal Privacy Laws. Information not originated by CentraCare Clinic cannot be released to another facility.

I understand that my medical record is part of the CentraCare Health (CCHS) Electronic Medical Record. CentraCare Health shares an electronic medical record with non-CCHS organizations. Authorizing the release of the following items: Medication List, Allergy List, Problem List, Immunization Data and/or Medical History includes the release of this information from all sites that share an electronic medical record.
A list of these non-CCHS organizations will be provided to the patient upon request.