

Authorization for Release of Health Information

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

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:	<input type="checkbox"/> CentraCare Midsota Plastic Surgeons; 3701 12 th Street North; St Cloud MN 56303-1258	
	Name	
	Address	Phone Number
	City	State
	Zip Code	
Requesting Party Send information to:	<input type="checkbox"/> CentraCare Midsota Plastic Surgeons; 3701 12 th Street North; St Cloud MN 56303-1258	
	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: _____	
	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Procedure Notes <input type="checkbox"/> Diagnostic Test Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Consult Reports	<input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> All Records <input type="checkbox"/> Radiology Films
Special Disclosures	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Psychiatric <input type="checkbox"/> HIV _____ to _____ Concerning: _____	
	Date	Specific diagnosis or treatment
Preferred Method	<input type="checkbox"/> MyChart <input type="checkbox"/> Mail <input type="checkbox"/> CD	
Reason for Disclosure	<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Personal Use <input type="checkbox"/> Attorney <input type="checkbox"/> Insurance <input type="checkbox"/> 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
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.	

CentraCare Clinic 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.

