CentraCare Health Monticello
1013 Hart Boulevard
Monticello, MN 55362

Monticello Medical Group
1107 Hart Boulevard
Monticello, MN 55362
Phone # (763)271-2219
Fax # (763)271-2310

CENTRACARE Health
Monticello

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 treatment.

MRN_____

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:** **___Hospital** **___Clinic** **___Both**	☐ CentraCare Health Monticello; 1013 Hart Boulevard; Monticello MN 55362 ☐ Monticello Medical Group; 1107 Hart Boulevard; Monticello MN 55362 Name Address Phone Number City State Zip Code
Requesting Party **Send information to:**	☐ CentraCare Health Monticello; 1013 Hart Boulevard; Monticello MN 55362 ☐ Monticello Medical Group; 1107 Hart Boulevard; Monticello MN 55362 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 :_____** ☐History and Physical ☐Discharge Summary ☐Consult Reports ☐All Records ☐Emergency Room Notes ☐Operative/Procedure Reports ☐Pathology Reports ☐Other (please specify) ☐Progress Note-Physician ☐Progress Note-Nurse ☐Progress Note-Other ☐Laboratory Reports ☐Radiology Reports ☐Radiology Films
Special Disclosures	___Chemical Dependency ___Psychiatric ___HIV _____to _____Concerning:_____ Date Date Specific diagnosis or treatment
Preferred Method	___MyChart ___Mail ___Pick-Up ___CD
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
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 Health 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 Health cannot be released to another facility. I understand that my medical record is part of the CentraCare Health (CCH) Electronic Medical Record. CentraCare Health shares an electronic medical record with non-CCH 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-CCH organizations will be provided to the patient upon request.

TJO 03/20/15