CentraCare™

Authorization for Release of Health Information

MRN_____

Please Print

CentraCare Monticello
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Monticello, MN 55362
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Patient Information	Name		Date of Birth
	Address		Phone Number
	City	State	Zip Code
	Previous Name		
Release Information From	Specific CentraCare Clinic / Hospital or Provider		
	Address		Phone Number
	City	State	Zip Code
Release Information To	Name of Person, Business, Specific Clinic / Hospital or Provider		
	Address		Phone Number
	City	State	Zip Code
Information to Be Released **Only the information selected will be released**	**Date(s) of service: From: _____ To :_____** **Note: If dates are not specified, only the most recent visit/encounter will be released.** ___ History and Physical ___ Pathology Reports ___ *Radiology Films ___ Discharge Summary ___ Consult Reports ___ All Records listed (*not included) ___ Emergency Room Notes ___ Laboratory Reports ___ Other (please specify) ___ Progress Notes ___ Operative/Procedure Notes _____ ___ Assessments/Evaluations ___ Radiology Reports		
Special Disclosure	___Substance Use Disorder Dates of Service: From: _____To:_____ Concerning: _____ (Specific diagnosis or treatment – do not list ICD-10 codes) *Per Federal Rule 42 CFR Part 2, this section must be completed to release Substance Use Disorder records.*		
Preferred Method	___ MyChart (If you do not have MyChart access, please visit www.centracare.com) ___CD ___ Paper ___Other _____		
Reason for Release	___Continuation or Transfer of Care (to another provider) ___Personal Use ___Attorney ___Insurance ___Other (specify)_____		
Authorization	**Patient/Guardian Signature**		**Date** / /
	Relationship to Patient		**Reason Patient is Unable to Sign**
Revocation	This authorization will expire one year from the date I sign unless I indicate a different date or event here:_____ This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it or upon final disposition of the conditional release for which authorization was given. I may revoke this authorization at any time by notifying, in writing, the provider/facility listed in the FROM section. I understand that such revocation 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 will not refuse treatment to any patient that refuses to sign an authorization for release of Protected Health Information. CentraCare cannot prevent redisclosure of your information by the person/organization who receives your records under this authorization, and your information may not be covered by state and federal privacy protections after it is released. If CentraCare has received records from other organizations, used them, and filed them in the record maintained about you, those records may also be included in any release of information. I understand that my records are part of the CentraCare Electronic Medical Record. CentraCare shares an electronic medical record with non-CentraCare 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-CentraCare organizations will be provided to the patient upon request.