AUTHORIZATION TO RELEASE HEALTH INFORMATION

Lake Region HEALTHCARE
Vision. Integrity. Award winning care.

Patient Information

Name: _____ **Maiden Name / Alias:** _____

Date of Birth: _____ **Phone (Home):** _____ **(Cell):** _____

Health Information Released FROM:

☐ **Lake Region Healthcare Hospital** **Phone: (218) 736-8479** **Fax: (218) 736-8757**
☐ **Lake Region Healthcare Clinic Services** **Phone: (218) 739-6813** **Fax: (218) 739-6692**
☐ **Other:** _____

Person / Organization _____
Street Address _____
City / State / Zip: _____ _____ _____
FAX: _____ Phone: _____

Health Information Released TO:

☐ **Lake Region Healthcare Hospital** **Phone: (218) 736-8479** **Fax: (218) 736-8757**
☐ **Lake Region Healthcare Clinic Services** **Phone: (218) 739-6813** **Fax: (218) 739-6692**
☐ **Other:** _____

Person / Organization _____
Street Address _____
City / State / Zip: _____ _____ _____
FAX: _____ Phone: _____

Health Information to be Released:

Service Date(s): _____ **Type of Visit:** ☐ **Hospital** ☐ **Clinic**

☐ History and Physical	☐ Photographs	☐ Radiology Rports
☐ Laboratory Reports	☐ Discharge Summary	☐ Radiology Images (not able to fax images)
☐ Emergency Room Report	☐ Progress Notes	☐ Stress Test
☐ Surgery Report	☐ Clinic Visit Notes	☐ Cardiac/EKG Reports
☐ Medications	☐ Care Plan	☐ Bills
☐ Other: _____		☐ Immunizations

All information regarding alcohol / drug use or abuse, mental health and/or HIV or AIDS <u>WILL NOT BE RELEASED</u> unless you tell us to by initialing below:

_____ Do Release Alcohol / Drug Use or Abuse Records
_____ Do Release Mental Health Records — NOTE: Psychotherapy notes will not be released without separate authorization.
_____ Do Release HIV/AIDS Records
_____ Other: _____

Purpose of Release:

☐ Personal ☐ Legal Purposes ☐ Continued Care **- Appt. Date:** _____
☐ Insurance ☐ Disability / Social Security ☐ Other: _____
There may be a charge / fee for copies of records.

Type of Release:

☐ Hard Copies (paper) ☐ Verbal Exchange (no copies)
☐ Review of Record (no copies)

Delivery Method

☐ **Mail** ☐ **Fax** ☐ **Pick up by patient** **Date Needed By:** _____

Authorization / Revocation

This authorization will terminate in one year unless otherwise specified: _____ .
I understand that I may revoke this release at any time by writing to the Lake Region Healthcare Health Information Department.
I understand that the revocation will not apply to information that has already been released in response to this authorization. Once the health information has been released, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Lake Region Healthcare will not condition treatment on whether I sign this form. I understand that I must sign this form to release my health information.

X _____
Signature

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority: ☐ Legal Guardian ☐ Next of kin

_____ _____
Relationship of Guardian to Patient: ***Date:***

Note: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.

A photocopy of this authorization is as valid as the original.

Staff Use Only

Visit ID # _____ **MR #** _____

Info Released By: _____ Date: _____ Form of ID _____ Other: _____