SLEEPY EYE MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name (First, Middle, Last)	Birth Date:	MRN:

Release Information From:

Name/Facility: ____

Address: ____

City, State, Zip: ____

Phone: ____

Fax: ____

Release Information To:

Name/Facility: ____

Address: ____

City, State, Zip: ____

Phone: ____

Fax: ____

Information To Be Released:

(Check all that apply)

- □ History & Physical
- □ Progress Notes
- □ Discharge Summary
- □ Operative Reports
- □ Clinic Notes
- □ Laboratory Reports
- □ Radiology Reports
- □ EKG/Telemetry
- □ Pathology Reports
- □ Images/Photos
- □ Immunization/Allergy Records
- □ ER Record
- □ Consultation Records
- □ Therapy Record (PT,OT,ST)
- □ Other: ____
- □ Mental Health Records
- □ Chemical Dependency/Substance Abuse Records
- □ Medication Records

Disclose only records related to the following:
Date(s) of service: ____ Injury or illness: ____________________________

Purpose of Release:

(Check one)

- □ Continuing Care
- □ Insurance Application *
- □ Transfer of Care
- □ Personal Use *
- □ Other ____

***Fees may be charged in accordance with state law.**

I understand that the information in my health record may include information related to sexually transmitted disease, HIV/AIDS, behavior and/or mental health care services and treatment for alcohol and drug abuse. I may revoke this authorization at any time by sending a written notice to the facility/provider releasing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: __________________

I understand this authorization is voluntary and that I may refuse to sign. By signing, you agree that you understand and accept the terms on this form.

Signature (required**)**	**Date Signed** (required) (Month DD,YYYY)
Relationship, If not Patient	