



**Patient Authorization to Use or Disclose Protected Health Information**

Patient Name \_\_\_\_\_ Maiden/Former Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_

INFORMATION RELEASED FROM (Name and address of releasing facility)	INFORMATION RELEASED TO (Name and address of receiving person/facility)
Name of facility	Name of facility
Address	Address
City, State, Zip	City, State, Zip
Phone number Fax number	Phone number Fax number
Or from the following Gateway Family Health Clinic (please circle one)	Or to the following Gateway Family Health Clinic (please circle one)
4570 County Hwy 61 <u>Moose Lake</u> , MN 55767 P: 218-485-4491 F: 218-485-4724  P.O. Box 309, 206 Main Street E <u>Hinckley</u> , MN 55037 P: 320-384-6618 F: 320-384-6635	204 Lundorff Drive <u>Sandstone</u> , MN 55072 P: 320-245-2250 F: 320-245-2555  P.O. Box 309, 206 Main Street E <u>Hinckley</u> , MN 55037 P: 320-384-6618 F: 320-384-6635

\_\_\_\_\_ I give permission for the above facilities to share notes and other information regarding continuing care for a period of one year starting on the date of signature below.

**Date(s) of service this authorization covers** \_\_\_\_\_ to \_\_\_\_\_

**\*\*GFHC originated records** (including lab, x-ray, etc) one year back are released according to policy with this authorization. If you are requesting additional year's history, we reserve the right to charge the current rate of \$1.22 per page, and a retrieval charge of \$16.03 per request for time spent copying records, according to MN State Statute 144.292 (Subd.6). **If you had care rendered at another facility please contact that facility for a copy of their original records.**

All information regarding chemical dependency, mental health, alcohol/drug abuse and HIV/STD testing **will NOT be** released unless specifically authorized by initialing below.

\_\_\_\_\_ Chemical Dependency      \_\_\_\_\_ Mental Health      \_\_\_\_\_ Alcohol/Drug Abuse      \_\_\_\_\_ HIV/STD

**PLEASE RELEASE THE FOLLOWING INFORMATION** (Check all that apply)

- Any and all medical records
- Physician notes
- X-ray reports
- X-ray films
- Cardiac testing
- Laboratory reports
- Bills and/or statements
- Other (please specify) \_\_\_\_\_

**PURPOSE OF DISCLOSURE** (Check all that apply)

- Continuing care
- Litigation
- Insurance
- Other (please specify) \_\_\_\_\_

I understand that if the person or entity that receives the information is not covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I do not authorize further release to any third party and hereby release the clinic, their employees and my physician(s) from any and all liability arising directly or indirectly from such redisclosure. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. A photocopy of this release will be considered valid as original. I understand that I may revoke this authorization in writing by contacting the Medical Records Department listed at the GFHC clinic address above. Unless otherwise revoked, this authorization expires in one year.

Patient/Guardian/P.O.A signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship of authorized representative to patient \_\_\_\_\_

Witnessed by \_\_\_\_\_ Date \_\_\_\_\_

ID of requestor verified \_\_\_\_\_ yes \_\_\_\_\_ no Method \_\_\_\_\_ Who verified \_\_\_\_\_

Records release date \_\_\_\_\_ By \_\_\_\_\_