Riverwood
HEALTHCARE CENTER

200 Bunker Hill Drive, Aitkin, MN 56431 | Fax: 218-927-5319

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION

Name _____ DOB _____ Phone _____

Address _____ City _____ State _____ Zip _____

RELEASE INFORMATION FROM (WHO HAS THE INFORMATION YOU WANT RELEASED?)

Name/Organization _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

RELEASE INFORMATION TO (WHERE DO YOU WANT THE INFORMATION SENT?)

Name/Organization _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

PURPOSE OF RELEASE (WHY IS IT NEEDED?)

☐ Continuing Care ☐ Worker's Compensation ☐ Legal ☐ Personal Use ☐ Insurance

☐ Disability Determination ☐ Other _____

Date Records Needed By _____ **Service Dates Between** _____ to _____

INFORMATION TO BE RELEASED

☐ **Routine Record Sets** (item a provider typically needs, such as labs, notes, procedures, and history, etc.)

☐ Physician Office Notes ☐ Operative/Procedure Notes ☐ Cardiology / EKG ☐ Radiology/XRay/MRI reports

☐ Radiology Images ☐ Chemical Dependency/Substance Abuse ☐ Psychological Testing/Mental Health

☐ Lab/Path Reports ☐ HIV/AIDS Testing ☐ Other _____

All information regarding chemical dependency will be released unless you restrict by initialing:

_____ Do not release chemical dependency information

_____ Do not release behavioral information

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and that the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. 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 consent to a claim under my policy. Unless otherwise revoked, this authorization expires once the above-stated purpose is fulfilled or one year, whichever comes first.

Patient/Legal Gaurdian Signature _____ Date _____

Requester Name _____ Date _____

Authority to act on behalf of patient (attach document) _____