



Authorization for Release of Health Information

For OMC Staff Use Only
Chart/MR #: _____
Released by: _____
Date released: _____

Please note: If any section is incomplete, this form becomes invalid.

Patient:	Name _____		
	Address _____		
	City _____	State _____	Zip _____
	Date of Birth _____	SSN _____	Phone _____
Health Information Released From:	I authorize the following facility/provider to release my health information upon this request:		
	Name _____	Specific office _____	
	Address _____	Phone/Fax _____	
	City _____	State _____	Zip _____
Health Information Disclosed To:	I authorize my health information to be disclosed to:		
	Name _____	Attn _____	
	Address _____	Phone/Fax _____	
	City _____	State _____	Zip _____
Health Information to be Disclosed:	Please note: If dates are not provided, only the last visit will be disclosed.		
	_____ Copies of clinic notes	from (date) _____	to (date) _____
	_____ Copies of hospital records	from (date) _____	to (date) _____
	_____ Psychology/Psychiatry records	from (date) _____	to (date) _____
	_____ Laboratory reports	from (date) _____	to (date) _____
	_____ Radiology Reports	from (date) _____	to (date) _____
	_____ X-ray films	from (date) _____	to (date) _____
	_____ HIV/AIDS Testing/Treatment	from (date) _____	to (date) _____
	_____ Alcohol/Drug Abuse Evaluation/Treatment	from (date) _____	to (date) _____
_____ Other (Please specify) _____			
Reason for Disclosure:	_____ Personal	_____ Disability	_____ Out of town move
	_____ Consult/Second Opinion	_____ Insurance Application	_____ Insurance change
	_____ Treatment	_____ Legal	_____ Other
Revocation:	I understand that I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, that I must do so in writing and present my written revocation to the Health Information 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 contest a claim under my policy. I understand that this authorization will be in effect for 12 months from the date signed unless revoked by me in writing and is only valid for the information specified above. If additional information is requested, a new authorization will be required. OMC will only release information that is dated up to the date signed.		
Authorization:	I understand that authorizing the release of this information is voluntary. I understand that I may inspect or be provided a copy of the information to be used or disclosed, as provided in CRF 164.524. I understand that any release of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I may contact Olmsted Medical Center's Privacy Officer. I understand that Olmsted Medical Center will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization. Please allow up to 30 days to process this release.		
	Patient/Parent/Guardian Signature (ages 18 and older must sign) _____		Date _____
	Relationship to Patient/Authority (please submit documentation of authority) _____		

Olmsted Medical Center Locations

Rochester Southeast 210 Ninth Street SE Rochester, MN 55904 507.288.3443	Hospital 1650 Fourth Street SE Rochester, MN 55904 507.529.6600	Byron Chatfield Pine Island	Plainview Preston Rochester Northwest St. Charles	Spring Valley Stewartville Wanamingo
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Translated Versions: Consent – Authorization for Release of Information: 1032407 – English 2080403 – Spanish 2080503 - Somali