OLMSTED MEDICAL CENTER

Authorization for Release of Health Information

For OMC Staff Use Only:
Request ID # _____
Patient MR#:_____
Release Date / By: _____

IMPORTANT: *This is a legal document; please complete each section to ensure we are able to process your request.*

Patient Name: _____ **Previous Name(s):** _____

Address: _____ **Apt #:** _____
(Street)

_____ **Date of Birth:** _____ **Phone:** _____
(City, State, Zip)

Release Information From:	☐ **Olmsted Medical Center (OMC-all locations), 210 Ninth Street SE, Rochester, MN 55904** ☐ **Other**: _____ Street: _____ Phone: _____ Fax: _____ City: _____ State: _____ Zip: _____
Release Information To:	☐ **Olmsted Medical Center (OMC), 210 Ninth Street SE, Rochester, MN 55904** ☐ **Other**: _____ Street: _____ Phone: _____ Fax: _____ City: _____ State: _____ Zip: _____
Method of Disclosure:	☐ Mail ☐ Pick up (*will call when ready)* ☐ Fax *(Urgent Only-limitations may apply)* ☐ Patient Portal *(limitations may apply)* ☐ File Only - No Records Needed at this time
Health Information to be Released:	**Date(s): Requesting From**:_____ **To**: _____*(specific date or date range preferred)* *If no specific date(s) are provided, only the most recent document(s) for items that are check marked below will be sent.* **All Medical Records For:** ☐ Clinic Visits ☐ Hospital Visits (inpatient and outpatient) **Or Specifically/Only:** ☐Clinic Visit Notes ☐ Laboratory/Pathology ☐Sleep Medicine ☐ Billing Records (sent separately) ☐Emergency Department Notes ☐ Immunization Record ☐Prenatal Records ☐ Radiology Report ☐Operative Reports ☐ Medication List ☐Allergies ☐ Radiology Image (sent separately) ☐Other(*Please Specify)*: _____. I understand the records to be released may include information related to evaluation or treatment of behavioral or mental health, alcohol and drug abuse, and HIV/AIDS. I understand this authorization releases records for dates requested above and may include records prepared or collected by the facility prior to the date of signature on this authorization and/or may include records prepared or collected by the facility after the date of the signature on this authorization.
Reason for Release:	☐ Consult/Treatment ☐ Insurance ☐ Out of town move ☐ Work Comp ☐ Disability ☐ Legal ☐ Personal ☐ Other: _____
Authorization Expiration:	This authorization is valid for one year from the date signed or a different time period provide by law or on the date/event specified here: _____.
Revocation:	I understand I have the right to revoke my 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 Health Information Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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.
Authorization:	I understand authorizing the release of this information is voluntary. I understand I may inspect or be provided a copy of the information to be used or disclosed, as provided in CRF 164.524. I understand 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 the facility's Privacy Officer. I understand the facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand this is a legal document and by signing, I agree that I understand and accept the terms on this form: _____ _____ / _____ / _____ Signature of Patient or Authorized Representative Date of Signature _____ _____ Printed Name of Authorized Representative Relationship to Patient or Description of Legal Authority ***(documentation of legal authority required, please submit)***

Submit completed form to any OMC location; mail to Olmsted Medical Center, 210 Ninth Street SE, Rochester, MN 55904;
or fax to 507.287.2777 Attention - Release of Information.
Questions: 507.287.2752

Translated Versions – Consent – Authorization for Release of Information: English – 1032407 Spanish – 2080403 Somali – 2080503