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 – Main Clinic	Rochester – Hospital	Byron	Plainview	Spring Valley
210 Ninth Street SE	1650 Fourth Street SE	Chatfield	Preston	Stewartville
Rochester, MN 55904	Rochester, MN 55904	Northwest (Rochester)	St. Charles	Wanamingo
507.288.3443	507.529.6600	Pine Island		

Translated Versions: Consent – Authorization for Release of Information: 2033103 – English 2080403 – Spanish 2080503 - Somali