

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient _____ MeritCare Chart No. _____
Perham MR#: _____

Date of Birth: _____ Social Security Number _____ - _____ - _____
(Optional)

I authorize: _____ To release to: _____

**SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED
(specify dates for each, unless "entire medical record" is selected)**

_____ Treatment from _____ (date) to _____ (date) MeritCare PMHH
_____ Pathology Report
_____ Entire Medical Record for all dates
_____ Hospital Admission Summary
_____ Hospital Discharge Summary
_____ Operative Report
_____ Progress/Clinic Notes
_____ Other (please specify) _____
_____ Lab reports
_____ Radiology Report
_____ Radiology Film
_____ Psychiatric Intake
_____ Immunizations

Verbal discussion only – do not release any written records.

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE: ___Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

PURPOSE OF THE USE AND DISCLOSURE

_____ Further Treatment (Date of Appointment _____) _____ Legal
_____ Insurance Application _____ Personal Records
_____ Disability Determination _____ Education
_____ Vocational Rehabilitation Evaluation _____ Payment of Insurance Claims
_____ At my request
_____ Other _____

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

Signature of Patient/Guardian/Representative _____ Date _____

(If not patient, state authority/relationship) Identification type/checked: _____

Completed: Initials: _____