AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient____ MeritCare Chart No.____________
Perham MR#:__________

Date of Birth:________________________ Social Security Number_____-_______-_______

I authorize: To release to:

Perham Memorial Hospital and Home
665 3rd St SW
Perham, MN 56573

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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 Notes
______Lab reports
______Radiology Report
______Radiology Film
______ Psychiatric Intake
______Immunizations
______Other (please specify)____
______I authorize verbal and/or written exchange about my medical information

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________**)
_____Insurance Application
_____Disability Determination
_____Vocational Rehabilitation Evaluation
____Legal
_____Personal Records
_____Education
_____Payment of Insurance Claims
_____Other ____
_____At my request

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 is 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

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

Revised: 3-28-03