ALOMERE HEALTH
Here for Life

111 17th Ave East
Alexandria, MN 56308
Phone: 320-762-1511
Fax: 320-762-6127

Alexandria Clinic
610 30th Ave West
Alexandria, MN 56308
Phone: 320-763-5123
Fax: 320-763-7883

Heartland Orthopedics
111 17th Ave East,
Suite 101
Alexandria, MN 56308
Phone: 320-762-1144
Fax: 320-762-1935

VERBAL RELEASE FORM

Patient Name____Date of Birth:_____________________

Previous Name(if any): _________________________________Phone Number: __________________

Street Address: _______________________________________ Last 4 Digits SSN: ________________

City: _________________ State: ________ Zip Code: ________Internal Use MRN#:_______________

This will authorize these facilities to verbally release information as designated below, to the following individuals for the purpose of assisting with my health care and/or finances, unless otherwise noted. This verbal release form does not include hard copies and/or electronic copies of medical records.

Name:	Relationship:	Phone Number:
☐ **All Medical Records* (Including Billing and Appointment)**	☐ **Billing Information Only**	☐ **Appointment Information Only**
Name:	Relationship:	Phone Number:
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Name:	Relationship:	Phone Number:
☐ **All Medical Records* (Including Billing and Appointment)**	☐ **Billing Information Only**	☐ **Appointment Information Only**

- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- **Special Disclosure:** With the exception of Psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency, STD and/or AIDS/HIV related illness/testing will **not be** verbally released unless otherwise indicated by initialing here: _____________
- I understand that once information is verbally released pursuant to this authorization, these facilities cannot prevent the re-disclosure of the information to another third party.
- These facilities will not condition treatment on my signing this authorization.
- This authorization will automatically expire one year from the date of my signature, ***or*** _______________ (period of time, for example, 2 days, 3 weeks or 5 months) from the date of my signature, *if specified here.* The expiration period noted here may exceed one year only in certain situation as specified in Minnesota statute 144.335 3a: for release to a provider in connection with current treatment: for release for purposes of payment claims, fraud investigation or quality of care.. As noted above, I understand I may revoke this authorization by written request at any time to the address listed above.
- I understand this authorization **must be filled out completely**, signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.
- This facility shares an electronic medical record with CentraCare Health System organizations and other Non-CentraCare Health System affiliates. Authorizing the verbal release of the following items: Medication List, Allergy List, Problem List, Immunization Data and/or Medical History includes the release of this information from all sites that share an electronic medical record. A list of these Non-CentraCare Health System affiliates is available on request.

Signature of Patient/Authorized Person	Authorized Person's Authority to Sign (Parent, Guardian, Health Care Agent, Etc)	Date

ID Checked:______ Copy For Patient:______ Patient Declined Copy:______ In Addition To: _______