ALOMERE HEALTH
Here for Life

111 17th Avenue 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

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

Name:_____ Date of Birth: _____
Previous Name:_____Phone Number:_____
Street Address: _____
City: _____State: _____ Zip: _____ Internal Use: MRN#_____

This Will Authorize:
(Who has the information you would like released?)

Organization/Name:_____
Address: _____ Phone Number: _____
City: _____State: _____Zip: _____ Fax Number: _____

To Release Records To:
(Where do you want the information sent?)

Organization/Name:_____
Address: _____ Phone Number: _____
City: _____State: _____Zip: _____ Fax Number: _____
Relationship to Patient (If any) _____

Method of Sending:

☐ Mail ☐ Fax #:_____ ☐ In Person-**Picture ID Will Be Required**
(If someone other than you will be picking up records, print their name here:) _____
☐ ASAP Request ☐ Date Needed By: _____

Format of Records:

☐ Paper ☐ Electronic ☐ MyChart What is Mychart? Refer to: https//mychart.centracare.com/mychart/default.asp?mode=stdfile&option=faq

Information to be Disclosed:
(Indicate only the information you are authorizing to be released)

Dates of Service: From: _____ To: _____

_____Operative Reports
_____Discharge Summary
_____Consultation Reports
_____History and Physical Reports
_____Laboratory/Pathology Reports
_____Progress Notes
_____Other (Specify)
_____Nursing Notes
_____Emergency Room Reports
_____Rehabilitation (PT/OT/ST)
_____X-ray/Radiology Reports ____ X-ray Films
_____EKG/Echo/Cardiology
_____Medication Records
_____ Billing

*If no dates of service are requested, one year of health information will be provided.

Special Disclosure:

☐ HIV/AIDS ☐ STD ☐ Chemical Dependency ☐ Mental Health (Psychotherapy Notes Require A Separate Release)

Reason for Disclosure:

☐ Continuing Care ☐ Legal/Attorney ☐ Insurance Claim ☐ Personal Use ☐ Relocating
☐ Disability ☐ Patient Review ☐ Billing Purpose ☐ Referral ☐ Other _____

Revocation:

- 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.
- 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: for release to an external researcher solely for purposes of medical or scientific research.
- I understand that the organization receiving the information will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

Additional Information:

- I understand that once information is released pursuant to this authorization, this facility cannot prevent the re-disclosure of the information to another third party and may no longer be protected by federal or state privacy laws.
- 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.
- As noted above, I understand I may revoke this authorization by written request at any time to the authorized address listed above.
- I understand there may be a retrieval and copy charge associated with the release.
- This facility shares an electronic medical record with CentraCare Health System organizations and other Non-CentraCare Health System affiliates. Authorizing the 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.

Authorization & Verification:

_____ _____ _____
SIGNATURE OF PATIENT/AUTHORIZED PERSON RELATIONSHIP TO PATIENT DATE

Reason patient is unable to sign ☐ Minor ☐ Deceased ☐ Incompetent ☐ Other _____
Internal Use: ID Checked:_____ Copy for Patient:_____ Patient Declined Copy: _____