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Mankato, MN 56001
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Authorization to Release Protected Health Information

Patient Information	Name:		Date of Birth:
	Address:		Phone:
	City:	State:	Zip:
	Previous Name:		
Health Care Facility/ Provider	**Who has the information you want released?**		
	Name:		Location:
	Address:		Fax #:
	City:	State:	Zip:
Requestor	**Where should the information be released?**		
	Name:		Location:
	Address:		Fax #:
	City:	State:	Zip:
Information to be Released/ Disclosed	Release Records Concerning: _____ Specific diagnosis or treatment or specific dates of service		
	☐ Entire Patient Record ☐ Office Notes/Procedures ☐ Lab Results/Pathology Reports ☐ Record of mental health or substance abuse treatment ☐ Record of HIV and communicable disease testing	☐ Financial/Billing ☐ Hospital notes ☐ X-Rays ☐ Nursing home, home health, hospice and other physician records ☐ Other: _____	
Reason for Release/ Disclosure	☐ Legal ☐ Insurance ☐ Personal	☐ Continuation of Medical Care ☐ Transferring Care ☐ Other: _____	
Revocation	I understand that this authorization will be in effect for 12 months from the date signed unless I specify an earlier termination. I must submit a new authorization form after the expiration date to continue the authorization. **Please list an earlier expiration date, if earlier than 12 months: _____**		
Authorization & Signature	I understand that I have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. The practice places no condition to sign this authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.		
	Signature of Patient or Authorized Representative: _____ **Date: _____**		

*You have the right to receive a copy of signed authorizations upon request.
*Authorized representative may be required to submit copies of legal documents supporting their authority to act on a patient's behalf.

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