RIVER'S EDGE
Hospital & Clinic

1900 North Sunrise Drive, St. Peter, MN 56082
Hospital: (507) 931-2200 Clinic: (507) 934-7682
HIM FAX NUMBER: (507) 934-7648

Medical Record Number:_____

Account Number:_____

Authorization for Release of Health Information

1. I hereby authorize _____
   Name of Facility (River's Edge Hospital & Clinic or other facility/provider maintaining health information)
   to release/disclose information from the medical records of:

   Patient's Name:_____ _____
   Last First Middle Maiden/Other Date of Birth

   Address:_____
   Street Address or PO Box City State Zip Code

   Daytime Telephone Number:_____ Alternate Telephone Number:_____

2. This information is to be released to:_____
   Name of Representative, Company, Attorney, etc.

   _____
   Street Address or PO Box City State Zip Code

3. Medical records to be released/disclosed, including reports involving alcohol, drug abuse, psychiatric treatment, sexually transmitted diseases, AIDS/HIV infection (if applicable):

( ) Complete medical records	( ) River's Edge Clinic Notes	
( ) History & Physical Examination	( ) Progress Notes	( ) X-Ray Reports
( ) Discharge Summary	( ) Operative Report	( ) Laboratory Reports
( ) Consultation Reports	( ) Pathology Reports	( ) Outpatient Information
( ) Emergency/Urgent Care Reports	( ) Photographs, videotapes, digital or other images	

   ( ) Other (specify):_____

   From the date of _____ through the date of _____

   Concerning (Specific diagnosis or treatment, auto accident, etc., if known):_____

4. These records are required for the purpose(s) of _____
5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the facility or practitioner responsible for releasing the information (for REHC – to the Health Information Management Department). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6. Unless otherwise revoked, this authorization will expire on this date/event:_____
   If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.
7. I understand that once information is released pursuant to this authorization the facility or physician named above cannot prevent the re-disclosure of that information if the party receiving the information is not bound by federal privacy laws. River's Edge Hospital & Clinic, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
8. I understand authorizing the use or release of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
9. I understand there may be a fee charged for copying and releasing information.

Signed:_____ _____
Signature of Patient Date of Signature

- OR - Signed:_____ _____
Signature of Personal Representative* Date of Signature
*(May be requested to provide verification of representative status)

_____ _____
Relationship to Patient Reason Patient is Unable to Sign

Signature of Witness (Optional):_____ Date:_____

Date Received:_____ Date Completed:_____ HIM Signature:_____
Information Released: