RIVER'S EDGE
HOSPITAL • ST. PETER

1900 North Sunrise Drive
St. Peter, MN 56082

Hospital: 507-931-2200 HIM FAX Number: 507-934-7648

Medical Record Number: _____

Authorization for Release of Health Information

1. I hereby authorize _____
   Name of Facility (River's Edge Hospital 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/PO Box City State Zip Code

   Daytime Phone Number: _____ Alternate Phone Number: _____

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

   _____
   Street Address/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	( ) X-Ray Reports
( ) History & Physical Examination	( ) Progress Notes	( ) Laboratory Reports
( ) Discharge Summary	( ) Operative Report	( ) Outpatient Information
( ) Consultation Reports	( ) Pathology Reports	
( ) 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 REH - 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, 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: _____ Date: _____
Signature of Patient

-OR Signed: _____ Date: _____
Signature of Personal Representative*
*(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: _____