

RIVER'S EDGE Hospital & Clinic

1900 North Sunrise Drive, St. Peter, MN 56082
Hospital Phone: (507) 931-2200

HEALTH INFORMATION 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 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, Hospital, Clinic, etc.

Street Address or PO Box City State Zip Code

Release Format: Printed - Mail Printed - Pick-Up at REH Release to Patient's MyChart Account

Fax – Fax Number: _____

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Complete medical records | <input type="checkbox"/> River's Edge Clinic Records | <input type="checkbox"/> Radiology Images (on a disc) |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Outpatient Information |
| <input type="checkbox"/> Emergency/Urgent Care Reports | <input type="checkbox"/> Photographs, videotapes, digital or other images | |
| <input type="checkbox"/> Billing Records-Itemized Bills | <input type="checkbox"/> 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 (Check one): Patient Request Treatment/Continued Care
 Legal Payment Worker's Compensation Other (please specify): _____

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: _____
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: _____