

Patient Authorization to Use or Disclose Protected Health Information

I authorize the facility/physician named below to release confidential information TO the following Gateway Family Health Clinic Ltd.

Name of facility/physician: _____
Address of facility/physician: (Street/PO Box) _____
City _____ State: _____ Zip: _____
Phone # of facility/physician: _____

(Circle the GFHC clinic you want records sent TO)

4570 Cnty Hwy 61	204 Lundorff Drive
<u>Moose Lake</u> MN 55767	<u>Sandstone</u> MN 55072
218 485-4491 Fax 218 485- 4724	320 245-2250 Fax 320 245- 2555

206 Main Street E
Hinckley MN 55037
320 384- 6618 Fax 320 384-6635

Date(s) of service this authorization covers : _____ to _____
(mm /dd/yy – please note fee arrangement below)

****GFHC originated records (including lab, x-ray, etc) one year back are released according to policy with this authorization. If you are requesting additional year's history, we reserve the right to charge the current rate of \$1.22 per page, and a retrieval charge of \$16.03 per request for time spent copying records, according to MN State Statute 144.292 (Subd.6). If you had care rendered at another facility please contact that facility for a copy of their original records.**

REQUESTED Information to be released: (check all that apply)

1. X-ray Films
2. Medical Records (If applicable, this may include any records related to chemical dependency, HIV/Aids, and mental health records).
3. Bills and/or Statements
4. Other: _____

****Or****

I authorize release of the above defined Gateway Family Health Clinic confidential information TO:

Name of facility/physician: _____
Address of facility/physician: (Street/PO Box) _____
City _____ State: _____ Zip: _____
Phone # of facility/physician: _____

This disclosure is being made for the purpose(s) of: Continuing care/treatment Litigation Other
I understand that if the person or entity that receives the information is not covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I do not authorize further release to any third party and hereby release the clinic, their employees and my physician(s) from any and all liability arising directly or indirectly from such redisclosure. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. A photocopy of this release will be considered valid as original.

I understand that I may revoke this authorization in writing by contacting the Medical Records Department listed at the GFHC clinic address above. Unless otherwise revoked, this authorization expires in one year.

Patient Name: _____ Date of Birth: _____ PH# _____
Patient Mailing Address (Street/PO Box) _____
City: _____ State: _____ Zip: _____

Patient /Guardian/ P.O.A signature: _____ Date: _____

Witnessed by: _____ Date: _____

ID of requestor verified? _____ Method: _____ Who verified: _____
Records Release Date: _____ By: _____