SIMPLICITY Health

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PHONE: 320.227.5000 FAX: 320.227.5025

Authorization for Release of Health Information

Please see Directions for additional information on completing.
Please Print

Patient Information	Name _____ Date of Birth _____ Address _____ Phone Number _____ City _____ State _____ Zip Code _____ Previous Name _____
Release Information From	Specific CentraCare Clinic / Hospital or Provider _____ Address _____ Phone Number _____ City _____ State _____ Zip Code _____
Release Information To	Name of Person, Business, Specific Clinic / Hospital or Provider _____ Address _____ Phone Number _____ City _____ State _____ Zip Code _____
Information to Be Released Only the information check marked will be released	**Date(s) of service: From: _____ To : _____** **Note: If dates are not specified, only the most recent visit/encounter will be released.** ___ History and Physical ___ Pathology Reports ___ Radiology Reports ___ Discharge Summary ___ Consult Reports ___ *Radiology Films ___ Emergency Room Notes ___ Laboratory Reports ___All Records (*not included) ___ Progress Notes ___ Operative/Procedure Notes ___ Assessment/Evaluation ___ Other (please specify) _____
Special Disclosure	___Substance Use Disorder Dates of Service: From: _____ To: _____ Concerning: _____ (Specific diagnosis or treatment – do not list ICD-10 codes) *Per Federal Rule 42 CFR Part 2, this section must be completed to release Substance Use Disorder records.*
Preferred Method	___ MyChart (If you do not have MyChart access, please visit www.centracare.com) ___CD ___ Paper
Reason for Release	___Continuation or Transfer of Care (to another provider) ___Personal Use ___Attorney ___Insurance ___Other (specify) _____
Authorization	Patient/Guardian Signature _____ Date ___/___/___ Relationship to Patient _____ Reason Patient is Unable to Sign _____
Revocation	This authorization will expire one year from the date of signature unless I indicate a different date or event here: _____ This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it or upon final disposition of the conditional release for which authorization was given. I may revoke this authorization at any time by notifying, in writing, the provider/facility listed in the FROM section. I understand that such revocation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.