Authorization for Release of Medical Records

Patient Name: _____ **Date of Birth:** _____

Phone Number _____ **MRN:** _____

RELEASE INFORMATION FROM:

Simplicity Health
3290 42nd Ave S
St. Cloud, MN 56301
Phone: 320-227-5000 **Fax: 320-227-5025**

RELEASE INFORMATION TO:

Name: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Preferred Method: Print ____ Fax____

RELEASE CONTENT: Only information that is checked will be released.

Dates of Service: _____

____Face Sheet	____Path Report	____Lab	____Other_____
____Discharge Summary	____ED Record	____Xray	____Billing
____H & P	____Progress Note	____EKG	
____Op Note	____Nursing Note	____Stress Test	
____Procedure Note	____PT/OT/ST Notes	____Echocardiogram	

SENSITIVE MATERIALS: I authorize the release of information about the following sensitive information if it is contained within the medical record: (If your entire medical record is being released, please check those pieces of highly sensitive health information you are authorizing to be released.):

____HIV Test Results	____Sexually Transmitted Diseases
____Alcohol & Drug Abuse Records	____Psychiatric Information
____Other/List Specific Items: _____	

REASON FOR DISCLOSURE: My health information is being released or disclosed for the following reasons:

____Personal	____Other_____
____Continuation or Transfer of Care	

I understand that after I have signed this form, if I change my mind I may cancel (revoke) this authorization at any time by notifying Simplicity Health in writing. This authorization will expire one year from the date of signature unless otherwise indicated_____. Cancellation of the authorization will not apply to information that has already been released based on this authorization.

_____ _____ _____

Signature of Patient or Patient Representative **Date** **Print Name of Patient**

(Do not sign until the information above is filled out completely.)