

Authorization for Release of Medical Records

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

Phone Number _____ **MRN:** _____

RELEASE INFORMATION FROM:

Name: _____

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

Phone: _____ **Fax:** _____

RELEASE INFROMATION TO:

Simplicity Health

3290 42nd Ave S
St. Cloud, MN 56301

Phone: 320-227-5000 **Fax: 320-227-5025**

Preferred Method: Print _____ Fax _____

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

Dates of Service: _____

- | | | | |
|--------------------------------------------|-----------------------------------------|-----------------------------------------|--------------------------------------|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Path Report | <input type="checkbox"/> Lab | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ED Record | <input type="checkbox"/> Xray | <input type="checkbox"/> Billing |
| <input type="checkbox"/> H & P | <input type="checkbox"/> Progress Note | <input type="checkbox"/> EKG | |
| <input type="checkbox"/> Op Note | <input type="checkbox"/> Nursing Note | <input type="checkbox"/> Stress Test | |
| <input type="checkbox"/> Procedure Note | <input type="checkbox"/> PT/OT/ST Notes | <input type="checkbox"/> 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.):

- | | |
|-----------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> HIV Test Results | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Alcohol & Drug Abuse Records | <input type="checkbox"/> Psychiatric Information |
| <input type="checkbox"/> Other/List Specific Items: _____ | |

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

- | | |
|-----------------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Personal | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> 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 _____.

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

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