Murray County Hospital & Clinic
2042 Juniper Avenue
Slayton, MN 56172
507-836-6111

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Patient Identification	Name_____Date of Birth:_____ MR#_____ Address:_____Phone #:_____ City/State/Zip:_____ Maiden/Previous Names/Nicknames:_____ Patient Social Security #:_____
Provider (Who is releasing information?)	Provider/Facility Name:__Murray County Memorial Hospital/Clinic_____ Address:_____2042 Juniper Avenue_____ City/State/Zip:_____ Slayton, MN 56172_____ Phone #:_____507-836-6111_____
Disclose Information to: (Where is information to be sent?)	Name/Facility:_____ Address:_____ City/State/Zip:_____ Phone #:_____
Information to be Released	❑ Clinic progress notes _____Physician's _____Nurse's _____Other ❑ Hospital progress notes _____Physician's _____Nurse's _____Other ❑ Immunization records ❑ Outpatient information ❑ Laboratory data ❑ EKG/cardiology reports ❑ Radiology reports ❑ Radiology films ❑ ER Records ❑ History & Physical ❑ Discharge summary ❑ Operative report ❑ Pathology report ❑ Psychiatric evaluation ❑ Treatment for drug/alcohol ❑ Consultation ❑ All records ❑ Other(specify)_____ _____
Service Dates	Time period from_____to_____ Concerning (Specific diagnosis or treatment, auto accident, etc.)_____ _____
Purpose of Disclosure	❑ Continuing medical care ❑ Insurance claim ❑ Consult/second opinion ❑ Other (specify)_____ ❑ Personal ❑ Legal ❑ Out of town move
Expiration Date	This authorization will expire one year from the date of signature or on _____
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.
Authorization	I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits. _____ _____ Signature of patient/representative Date of Signature _____ _____ _____ (Relationship to patient, if representative) (Reason unable to sign) (Witness, optional) Please supply proof of authority to act. For minors, proof only required if other than parent.
INTERNAL USE ONLY:	**Disposition:** **Authority to act attached _____** **Information needed by_____** **ID validated _____** **Date sent:_____ By:_____** **Authorization rec'd:_____**