

Main: 507.836.6111 Hospital Fax: 507.836.6700  
Slayton Clinic: 507.836.6153

Clinic Fax: 507.836.8787  
2042 Juniper Ave  
Slayton, MN 56172  
murraycountymed.org

AUTHORIZATION

FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

**I hereby authorize the use or disclosure of my individually identifiable health information by Murray County Medical Center to:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax:( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize the use or disclosure of my individually identifiable health information by Murray County Medical Center:**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial Maiden (if applicable)

Patient’s Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

Information to be released:

Date(s) of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specific Information to be released:**

* Clinic Progress Notes
* Hospital Progress Notes
* Immunization Records
* Outpatient Information
* Laboratory Data
* EKG/Cardiology Report
* Radiology Report/Films
* Emergency Room Records
* History and Physicals
* Discharge Summary
* Operative Report
* Pathology Report
* Psychiatric Evaluation
* Treatment for Drug/Alcohol Abuse
* Consultation
* HIV/AIDS Records
* All Records
* Other (specify):

**Reason for Request:**

* Continuing Medical Care
* School
* Legal Purposes
* Social Security/Disability
* Military
* Insurance
* Provider Changed Practice
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial Maiden (if applicable)

Patient’s Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

I understand that the specific information to be released will only include the items have checked above. If All Records was checked then all categories listed will be provided. I authorize release of this specific data. I also, understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information had been made prior to the receipt of the revocation.

This authorization expires one year from the date of signature, unless I specify otherwise or revoke my authorization. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or a health care provider the released information may no longer be protected by Federal Privacy Regulations.

I have read and understand this consent. I have signed this consent voluntarily and of my own free will.

