Authorization to Release Protected Health Information

309 Holly Lane • Mankato, MN 56001
507.388.2120 phone | 507.388.3924 fax

Patient Information

Name (First, MI, Last)____ Previous Name(s)___________________

Birthdate:___________________________ Phone:____

Mailing Address:________________________________ City:_______________ State______ Zip Code__________

I authorize Open Door Health Center to: ☐ Exchange with ☐ Disclose to ☐ Obtain from

Name of Agency or Individual: ____Relationship:__________________

Mailing Address: ____________________________ City: _______________________ State: ________ Zip: _________

Phone Number: ________________________ Fax Number:___________________________

Purpose of Release

☐ Treatment/Continued Care ☐ Transfer of Care (Provider Change) ☐ Personal ☐ Legal Purposes

☐ Disability determination ☐ Insurance ☐ Other: ____

Information to be Released

Release Via: ☐ All ☐ Written ☐ Verbal

☐ Past 2 yrs of Records Date range of records: _________________ Date information needed by: ________________

☐ Medical Notes/Procedures ☐ History & Physical ☐ Hospital Notes ☐ Hospital Discharge Summary

☐ Laboratory/Pathology Reports ☐ Immunization Records ☐ Operative Reports

☐ Radiology Reports ☐ Appointments/Scheduling ☐ Billing Statements Needed ☐ EKG's

☐ Dental Records ☐ Any and All Records ☐ Other: ____

☐ Psychiatry ☐ Chemical Dependency ☐ Behavioral Health (Specify) _____________________________

State and federal law protects the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No Dates ______________________________

HIV Testing and Results ☐ Yes ☐ No Dates ______________________________

Mental Health Records ☐ Yes ☐ No Dates ________________ Psychotherapy Records ☐ Yes ☐ No Dates ______________________

- This authorization is valid for one year after the signed date unless specified. ____
- I may terminate this authorization in writing at any time. A termination will not change releases that happened before notice of termination. Written termination of the authorization must be turned into the Medical Records Department, along with any questions regarding the authorization.
- I understand that signing this authorization is voluntary. I can refuse to sign the authorization.
  I need not sign this authorization in order to assume treatment.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and
  may no longer be protected by federal law.
- A photocopy of this authorization may be treated in the same manner as the original.
- My signature indicates that I have read and understand this form, and that I authorize the release of information as described above.

☐ Patient (18 or older) ☐ Parent of Minor ☐ Legal Guardian

*If the patient is **17 years of age or younger**, the Patients parent or legal guardian must sign and date this form.
*If a Behavioral Health patient is **16 years or 17 years of age,** both the Patient and Parent/Legal Guardian must sign and date this form.

______________________________ ______________________________ ____________

Patient Signature Printed Name Date

______________________________ ______________________________ ____________

Parent/Legal Guardian Signature Relationship to Patient Date

For Office Use Only: Initial When Scanned ________ BH ________ MED ________ DENTAL