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WINDOM AREA HOSPITAL
2150 HOSPITAL DRIVE
WINDOM, MN 56101



Authorization for Disclosure of Personal Health Information

Patient Identification	Name: _____ Date of Birth: _____ Address: _____ Phone Number: _____ City/State/Zip: _____ Maiden/Previous Names/Nickname: _____ Patient Social Security Number: _____		
Provider (Who is releasing information?)	Provider/Facility Name: _____ Address: _____ City/State/Zip: _____ Phone Number: _____		
Disclose Information To:	Name/Facility: _____ Address: _____ City/State/Zip: _____ Phone Number: _____ Fax: _____		
Information to be Disclosed	<input type="checkbox"/> Clinic Progress Notes ___ Physician's ___ Nurse's ___ Other <input type="checkbox"/> Hospital Progress Notes ___ Physician's ___ Nurse's ___ Other <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> EKG / Cardiology Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> ER Records <input type="checkbox"/> History & Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative Report <input type="checkbox"/> Immunization Record <input type="checkbox"/> Treatment for Drug or Alcohol Dependency	<input type="checkbox"/> Lab Data <input type="checkbox"/> Pathology Report <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Outpatient Information <input type="checkbox"/> Consultation <input type="checkbox"/> All Records <input type="checkbox"/> Clinical Assessment
Service Dates	Time period from: _____ to _____ Concerning: _____ (specific diagnosis or treatment, auto accident, etc.)		
Purpose of Disclosure	<input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Consult / Second Opinion <input type="checkbox"/> Legal	<input type="checkbox"/> Out of town move <input type="checkbox"/> Personal
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. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.		
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. I understand that the record may include provider records from other facilities or providers of care. I understand that this authorization is voluntary and that I may refuse to sign this authorization. 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	_____ Signature Date	
	_____ (Relationship to patient, if signed by representative)	_____ (Reason patient unable to sign)	_____ (Witness - optional)
Internal Use Only:	MR #: _____ Authorization Received: _____ (date)	Disposition Info needed by: _____ Date released: _____ Released by: _____	<input type="checkbox"/> Authority to act attached <input type="checkbox"/> ID Validated

