MILLE LACS HEALTH SYSTEM

200 North Elm Street • P.O. Box A • Onamia, MN 56359 • (320) 532-3154

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

____
Name of Patient/Previous Names

____
Birth Date/Medical Record Number

____
Street Address

____
City, State, Zip Code

AUTHORIZES:

____
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

____
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

Information to be released:	**Date Of Service**
( ) Info. Necessary for Cont. Care	________
( ) History and Physical	________
( ) Pathology Report	________
( ) Labs	________
( ) EKG/EMG/EEG	________
( ) Immunizations	________

	Date Of Service
( ) Discharge Summary	________
( ) Operative Procedure Report	________
( ) Consultations	________
( ) Xrays	________
( ) Progress Notes	________
( ) Other________________________	

(Contact Medical Imaging Department to obtain Films)

In compliance with Wisconsin and Minnesota Statutes which require special permission to release otherwise privileged information, please release records pertaining to:

( ) Alcohol Abuse or test results
( ) Drug Abuse or test results
( ) Mental Health
( ) Developmental Disabilities
( ) HIV test results, AIDS or AIDS related disease
( ) Sexually Transmitted Disease
( ) Other________________________

This disclosure is being made for the following puposes:

( ) Further Medical Care
( ) Relocation/moving
( ) Insurance change
( ) At the request of an individual
( ) Change Physicians (explain)________________________
____
( ) Work Comp
( ) Attorney/court case
( ) Insurance
( ) Other (comments)________________________
____
____

REDISCLOSURE NOTICE: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer protected by Federal Privacy standards. A photocopy or facsimile/scanned image will be treated as an original.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Services Dept. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** - I understand I am under no obligation to sign this form and that the person(s).and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services). **Right to Revoke This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Health Information Services Dept. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: Unless otherwise revoked, this authorization will expire on this date/event:________________________ or for one year from date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNED:______________________________ ______________
Signature of Personal Representative — Date of Signature

______________________________ ______________________________
Relationship to Patient — Reason Patient is Unable to Sign

Signature of Witness *(Optional)*:________________________ Date:______________

Date Received:______________ Date Completed:______________ HIM Signature:______________
Information Released: