CCM Health

Authorization for Release of Protected Health Information

Office use only MRN#: _____

Completed by/date: _____

Print patient's legal name: _____ Birth Date: _____

Previous name(s): _____ Phone: _____

1. **Please release my records from:** *(Who has your records? Please list the specific hospital and/or clinic.)*
   Name: _____
   Phone: _____ Fax: _____
   Address: _____ City: _____ State: _____ Zip: _____

2. **Release the records marked below for this condition or date(s) of treatment:** _____
   (If blank, we will release two years' worth of most recent records.)
   - ☐ Pertinent Clinic Record Set (office visit, lab/radiology, medications, immunizations)
   - ☐ Pertinent Hospital Record Set (emergency, operative, or discharge report, history and physical, lab/radiology)
   - ☐ Immunization records ☐ X-ray/Radiology films/CDs ☐ Emergency/Urgent Care reports
   - ☐ EKG/ECHO reports ☐ Lab/Pathology reports ☐ X-ray/Radiology reports
   - ☐ Other (please specify): _____

3. **Please release my records to:** *(Who needs your records? Where do you want the information sent?)*
   Name: _____
   Phone: _____ Fax: _____
   Address: _____ City: _____ State: _____ Zip: _____

4. **Format/delivery:** ☐ Paper Copy ☐ CD / ☐ Mail ☐ Fax ☐ Will pick up _____
   Date needed by: _____

5. **Purpose:** ☐ Continuing care ☐ Insurance ☐ Personal use ☐ Disability ☐ Legal ☐ Other _____

6. **I understand that:**
   - Except for psychotherapy notes (not included in medical record), the release of records listed in Section 2 may include details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions, and AIDS/HIV. **If I have received treatment for any of these conditions, I do not want the following records released:** _____
   - If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
   - Once the records are released to the name above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
   - I approve the release of records for future visits, starting from the date I sign this form through: _____.
   - There may be a fee for releasing these records.
   - A photocopy of this completed, signed form is considered valid if not altered.
   - If I do not sign this form, I will still get medical treatment, unless treatment is part of a research project.
   - This form expires one year after I sign it, or on _____, except in certain situations specified by law.

Once the records are released to the name above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

_____	_____	_____	_____
Date	***Time***	***Signature of patient or authorized person***	***If authorized person, print name and Description of authority to sign for patient (may require proof)***

Directions for Completing the Authorization for Release of Protected Health Information Form

Fill out the entire form neatly. Use clear handwriting.

Patient Information Section: This is about the patient who needs medical records. Please fill it out completely.

Section 1 - Release records from: Write down which clinic, hospital or facility has the medical records.

Section 2 - Records to be released:

- **For condition or dates of treatment:** Write down the condition or dates of treatment.
- Mark the box next to the information you want released. Check "other" to request records not listed. Please specify which records you need.

Section 3 - Please release my records to: Write down your name or the name of another person, healthcare facility, or organization that needs the medical records. (Please note: It is CCM Health's policy NOT to fax or email patient information except for direct patient care needs or by patient request, such as to a hospital or clinic.)

Section 4 - Delivery/format: Mark how you would like the records to be prepared and delivered. For additional questions, call 320-321-8280.

Section 5 - Purpose: Mark why you need a copy of the records. This will help track your request and assign priority status, if needed. It also informs us who may be responsible for the cost of the records (when appropriate).

Section 6 - I understand: Read the bulleted items. This consent will expire in 12 months unless you write in a different date. You may **stop** or **revoke** (take back) your consent by writing us. Sign and date the form, and include the time. If you are signing the document on behalf of the patient, proof of your legal authority may be requested. Proof examples: Power of Attorney (POA) for Healthcare, Advance Care Directive and court appointed Legal Guardianship documents.

Contact Information for Release of Information:

CCM Health
(Including satellite clinics: Clara City, Clarkfield, and Milan Clinics)
Health Information Management
824 North 11th Street
Montevideo, MN 56265
Phone: 320-269-8877
Fax: 320-321-8281

INFORMATIONAL PAGE ONLY