

X Patient Name: LAST FIRST MI      ℓ Date of Birth      Medical Record Number

I hereby authorize:

(Name and address of releasing facility)

To Release Information to:

(Individual name, facility/organization and address)

ℓ DC - Fax # 218-786-3070

St. Mary's Duluth Clinic Health System  
400 East Third Street  
Duluth MN 55805

Including attached addendum

Date & Time of Appointment

**PURPOSE OF DISCLOSURE:**

- Continuing Care
- Payment of Claim
- School
- Worker's Compensation
- Legal
- For Personal Use
- Other (specify):

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released **unless you restrict** by initialing below:

*Initial*

\_\_\_\_\_ Do not release Alcohol and/or Drug Abuse information

\_\_\_\_\_ Do not release Behavioral Health information

**INFORMATION TO BE RELEASED:**

Between Dates of: X to \_\_\_\_\_

- Discharge Summary
- H&P Exam/Initial Evaluation
- Consult
- CD Counselor/Therapist Reports
- Progress Notes/Provider Notes
- Orders
- Other (specify content and dates):

- X-Ray Reports
- X-Ray Films/MRI
- Diagnostic Test Reports
- Procedure Reports
- Lab Reports/Pathology
- Correspondence

- Psychological Testing
- Transfer/Outside Information
- Completed Form
- Exchange of Verbal Communication
- HIV related information (AIDS related testing)

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

- I understand the expiration date of this authorization is \_\_\_\_\_ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that SMDC may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.335 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as the original.
- I understand that: (1) my HIV test results may be released without my authorization to persons/ organizations that have access under Wisconsin law; and that (2) a list of those persons/ organizations is available upon request.

*If I am signing as Authorized Representative of the patient, I am:*

- Parent of minor
- Court appointed guardian/conservator

X Patient Signature

X Date

Signature of Authorized Person

Relationship to Patient



**AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

ITEM # 39275

White - Organization

Yellow - Patient

AUTH.001 Orig: 04/03 Rev: 12/04, 11/05, 6/06, 3/07