

1601Golf Course Road Grand Rapids, MN 55744 Phone: (218)326-3401

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

	Previous Names		
Address		NAD //	
Birthdate	Phone Number	MR#	
PROVIDER [Who has the information that you would like released?]	Name: Grand Itasca Clinic and H Address: 1601 Golf Course Road Grand Rapids, MN 55744 Phone: (218)326-3401	4	<u>99-1513 </u>
REQUESTOR [Where do you want the information to be sent?]	Name: Address Phone: Delivery Preference: Mail MyChart	Fax:	(Email Address)
INFORMATION TO BE RELEASED	 □ Clinic Notes □ Immunizations □ Exam Pathology Reports □ X-ray/Radiology Reports □ Films □ EKG/ ECHO Reports □ Other (please specify) Dates of Treatment or Condition 		Discharge Summary History and Physical Consultation Reports Lab Results Operative Reports Emergency Services
REASON FOR RELEASE	□ Continued care by another provi □ Attorney review □In □ Other (please specify)	surance claim purposes	
and/or AIDS/HIV related il I understand I may revoke to understand that the revocate This authorization will auto example 2 days, or 3 weeks exceed one year only in cel connection with current trea release to an external resea revoke this authorization by I understand there may be a I understand that once infor prevent the re-disclosure of I understand this authorizat photocopy that has not bee	notherapy notes, all records pertaining to Iness/testing will be released unless other inestination will not apply to information that has omatically expire one year from the dates, or 5 months) from my signature, if spectrain situations as specified in Minnesota attent; for release for purposes of paymer in a retrieval for purposes of medical or so written request at any time to the address a retrieval and copy charge associated with information to another third party, it is information to another third party, it is in must be filled out completely, signed in altered will be considered as valid as a treatment, Grand Itasca Clinic & Hospital	erwise indicated by initialing time to the address listed already been released in rese of my signature, or cified here. The expiration postatute 144.335 3a: for releasent of claims, fraud investigate in the release. In the release or ization, Grand Itasca Clinical and dated in order to be contain original.	at the top of this form. I sponse to this authorization (period of time, for eriod noted here may ase to a provider in ation or quality of care; for above, I understand I may
Signature of Patient / Authorized	Person Authorized Person's A (Parent, guardian, powe		Date