1900 North Sunrise Drive, St. Peter, MN 56082
Hospital: (507) 931-2200 Clinic: (507) 934-8480
HIM FAX NUMBER: (507) 934-7648

Medical Record Number:______________________________

Account Number:____________________________________

Authorization for Release of Health Information

Patient's Name:____ ____________________
Last First Middle Maiden/Other Date of Birth

Address:____
Street Address or PO Box City State Zip Code

Daytime Telephone Number:___________________________ Alternate Telephone Number:_________________

Choose one option:

☐ I hereby authorize River's Edge Hospital & Clinic, St. Peter, MN, to release medical information to:

____ ☐ Mail
Name of Representative, Company, Attorney, etc. ☐ Pick Up

____
Street Address or PO Box City State Zip Code

- OR -

☐ I hereby authorize ____
Name other facility/provider maintaining health information

____
Street Address of other facility/provider City State Zip Code

to release medical information to River's Edge Hospital & Clinic, St. Peter, MN
Attention:__________________ Fax Number:_________________________ Appointment Date:____________

1. Medical records to be released/disclosed, including reports involving alcohol, drug abuse, psychiatric treatment, sexually transmitted diseases, AIDS/HIV infection (if applicable): (Check all that apply)
   - ☐ Complete hospital medical records
   - ☐ History & Physical Examination
   - ☐ Discharge Summary
   - ☐ Consultation Reports
   - ☐ Emergency/Urgent Care Reports
   - ☐ Other (specify):____
   - ☐ Complete River's Edge Clinic records
   - ☐ Progress Notes / Clinic Notes
   - ☐ Operative Report
   - ☐ Pathology Reports
   - ☐ Photographs, videotapes, digital or other images
   - ☐ X-Ray / Imaging Reports
   - ☐ Laboratory Reports
   - ☐ Outpatient Information

   From the date of ___________________________ through the date of ____________________________

   Relating to (Specific diagnosis / illness / injury, if known):_____________________________________

2. These records are required for the purpose(s) of (Check one): ☐ Continuation of Medical Care ☐ Litigation ☐ Payment of Claim ☐ Worker's Compensation ☐ Other (Please specify)________________________
3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the facility or practitioner responsible for releasing the information (for REHC – to the Health Information Management Department). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
4. Unless otherwise revoked, this authorization will expire on this date/event:____
   If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.
5. I understand that once information is released pursuant to this authorization the facility or physician named above cannot prevent the re-disclosure of that information if the party receiving the information is not bound by federal privacy laws. River's Edge Hospital & Clinic, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
6. I understand authorizing the use or release of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
7. I understand there may be a fee charged for copying and releasing information.

Signed:____ ______________________________
Signature of Patient Date of Signature

- OR - Signed:____ ______________________________
Signature of Personal Representative* Date of Signature
*(May be requested to provide verification of representative status)

________________________________ ____
Relationship to Patient Reason Patient is Unable to Sign

Signature of Witness (Optional):____________________________________ Date:____________________________

Date Received:_______________ Date Completed:________________ HIM Signature:________________________________
Information Released: