



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:

Name of Representative, Company, Attorney, etc. Mail 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 Complete River's Edge Clinic records
History & Physical Examination Progress Notes / Clinic Notes X-Ray / Imaging Reports
Discharge Summary Operative Report Laboratory Reports
Consultation Reports Pathology Reports Outpatient Information
Emergency/Urgent Care Reports Photographs, videotapes, digital or other images
Other (specify):

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: