Back to your full range of living

Orthopaedic Associates OF DULUTH, P.A.

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AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

Patient Name: LAST FIRST MI _____ 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)

_____
_____
_____
_____

PURPOSE OF DISCLOSURE:
( ) Continuing Care
( ) Payment of Claim
( ) School
( ) Worker's Compensation
( ) Legal
( ) For Personal Use
( ) Other (specify): _____

I specifically authorize the release of information relating to:
( ) Substance abuse (including alcohol/drug use)
( ) Behavioral Health
( ) HIV related information (AIDS related testing)

_____ _____
Signature of Patient or Personal Representative Date

INFORMATION TO BE RELEASED:

	Between Dates of:		Between Dates of:
( ) Discharge Summary	_____	( ) X-ray Reports	_____
( ) H&P Exam/Initial Evaluation	_____	( ) X-Ray Films/MRI	_____
( ) Consult	_____	( ) Diagnostic Test Reports	_____
( ) Counselor/Therapist Summary	_____	( ) Procedure Reports	_____
( ) Progress Notes/Provider Notes	_____	( ) Lab Reports/Pathology	_____
( ) Others	_____	( ) Correspondence	_____
( ) Other (specify content and dates):	_____		
( ) Only Record of Doctor	_____		

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is 1 year.
- 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.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recepient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Stature 144.33 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.

_____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date