



Patient Name: _____

DOB: _____ Patient Id: _____

I hereby request and authorize:

Lake Superior Community Health Center

4325 Grand Ave
Duluth, MN 55807
Medical Fax: 218-727-8346
Medical Phone: 218-722-1497
Dental Fax: 218-624-6594
Dental Phone: 218-628-7035

3600 Tower Ave
Superior, WI 54880
Medical Fax: 715-392-1935
Medical Phone: 715-392-1955
Dental Fax: 715-392-5086
Dental Phone: 715-394-5411

- To:** Disclose to
 Receive from
 Exchange with

Name: _____

Address: _____

City/State/Zip: _____

PURPOSE FOR DISCLOSURE

- | | | |
|--|--|--|
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Legal Investigation or Action | <input type="checkbox"/> Billing/Payment of Insurance Claims |
| <input type="checkbox"/> Care Coordination/Case Management | <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Financial Assistance |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other, specify: _____ |

INFORMATION TO BE RELEASED

For the following date(s): From: _____ To: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Oral Information | <input type="checkbox"/> Alcohol/Drug Therapy Notes | <input type="checkbox"/> Mental Health/Psychotherapy Notes |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Diagnostic Test Results | <input type="checkbox"/> BH Screening Results |
| <input type="checkbox"/> Radiology/X-ray Report | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> BH Diagnostic Assessment |
| <input type="checkbox"/> Letters Correspondence | <input type="checkbox"/> Colonoscopy Results | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Pap Test and Mammogram Results | _____ |

I Understand:

- My health information being released may include information related to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and alcohol or drug abuse and dependence unless the box is checked.
 - Do not release my information regarding: _____
- The expiration date of this authorization is one year.
- I may revoke this authorization at any time by notifying the releasing organization in writing. It will be effective on the date notified except to the extent action has already been taken.
- This authorization is valid for records prior to and after the date signed.
- I may inspect and receive a copy of the material to be disclosed.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy standards.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- I understand if I agree to sign this authorization I must be provided with a signed copy of the form
- A photocopy or fax of this document is valid as the original.
- I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am authorizing Lake Superior Community Health Center to disclose/receive my above identified protected health information.

Signature or mark of patient, parent of minor, or personal representative	Relationship	Date
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Witness signature required if patient unable to sign but uses X or a mark	Date
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