LAKE SUPERIOR COMMUNITY HEALTH CENTER
caring for the health of the community

Patient Name: _____

DOB: _____ **Chart Number**: _____

I hereby request and authorize:

Lake Superior Community Health Center

☐ 4325 Grand Ave
Duluth, MN 55807
Medical Fax: 218-722-2468
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
ROI: 218-722-2468
Medical Phone: 715-392-1955
Dental Phone: 715-394-5411 Fax: 715-392-5086

To:
- ☒ Disclose to
- ☒ Receive from
- ☒ Exchange with

Name: _____

Address: _____

_____

City/State/Zip: _____

REASON FOR DISCLOSURE
- ☒ Continuation of Care
- ☒ Care Coordination/Case Management
- ☒ Personal
- ☒ Legal
- ☒ Transfer of Care
- ☒ Disability
- ☒ Billing/Payment of Claims
- ☒ Financial Assistance
- ☒ Other, specify:_____

_____

EXTENT OF INFORMATION
- ☒ Between the dates of

_____and

_____
- ☒ Only records of_____

TYPE OF INFORMATION
- ☒ Verbal Information
- ☒ Progress Notes
- ☒ Radiology/X-ray Report
- ☒ Letters Correspondence
- ☒ Immunization Records
- ☒ Alcohol/Drug Therapy Notes
- ☒ Diagnostic Test Results
- ☒ Laboratory Report
- ☒ Colonoscopy Results
- ☒ Pap Test and Mammogram Results
- ☒ Mental Health/Psychotherapy Notes
- ☒ BH Screening Results
- ☒ BH Diagnostic Assessment
- ☒ Other, please specify:_____

_____

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.
- 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 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photo-copying of records and/or supervising inspection of medical/dental records.
- I may inspect and receive a copy of the material to be disclosed.
- I may receive a copy of the signed authorization upon request.
- A photocopy or fax of this document is valid as the original.

_____ _____ _____

Signature or mark of patient, parent of minor, or personal representative **Relationship** **Date**

_____ _____

Witness signature required if patient unable to sign but uses X or a mark **Date**

IF SIGNED BY THE PATIENT'S PARENT OR PERSONAL REPRESENTATIVE, SUPPORTING LEGAL DOCUMENTATION MUST ACCOMPANY THIS AUTHORIZATION FORM.