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
Dental Fax: 218-624-6594
Dental Phone: 218-628-7035
Medical Fax: 218-727-8346
Medical Phone: 218-722-1497

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

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
☐ X-ray Report
☐ X-ray Films
☐ Letters Correspondence
☐ Itemized Billing Statement
☐ Other (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 photocopying 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.