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

Patient Name: _____

DOB: _____ **Patient Id**: _____

I hereby request and authorize Lake Superior Community Health Center

☐ 4325 Grand Ave Duluth, MN 55807 **Phone:** 218-722-1497
Medical Fax: 218-722-2468 **Dental Fax:** 218-624-6594

☐ 3600 Tower Ave Superior, WI 54880 **Phone**: 715-392-1955
Medical Fax: 218-722.2468 **Dental Fax:** 715-392-5086

☐ 1500 N. 34th St Ste. 200 Superior, WI 54880
Phone: 715-395-5380 **Fax:** 218-722-2468

To:

☐ Disclose to ☐ Receive from ☐ Exchange with

Name: _____

Address: _____

City/State/Zip: _____

PURPOSE FOR DISCLOSURE

☐ Continuation of Care
☐ Care Coordination/Case Management
☐ Personal
☐ Legal Investigation or Action
☐ Transfer of Care
☐ Disability Determination
☐ Billing/Payment of Insurance Claims
☐ Financial Assistance
☐ Other, specify: _____
_____

INFORMATION TO BE RELEASED

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

☐ Oral Information
☐ Progress Notes
☐ Radiology/X-ray Report
☐ Letters Correspondence
☐ Immunization Records
☐ Alcohol/Drug/Substance Abuse 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.
- 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.
- 42 CFR Part 2 prohibits further re-disclosure of records related to substance abuse.

_____ _____ _____

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.