LAKE SUPERIOR COMMUNITY HEALTH CENTER
Improving Access to Quality Health Care for All

Patient Name: _____

DOB: _____ **Patient ID**: _____

I hereby request and authorize Lake Superior Community Health Center to: ☐ **Disclose to** ☐ **Receive from** ☐ **Verbally exchange with**

☐ 4325 Grand Ave Duluth, MN 55807 **Phone:** 218-722-1497
Medical/BH Fax: 218-722-2468

☐ 4602 Grand Ave. Suite 1000, Duluth, MN 55807
Phone: 218-336-3520 **Fax:** 218-628-6097

☐ 210 3rd St, Carlton MN 55718
Phone: 218-336-3524 **Fax:** 218-384-9002

☐ 2222 East 5th Street, Superior, WI 54880
Phone: 715-392-1955
Medical/BH/AODA Fax: 218-722-2468

Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____ **Fax #:** _____

Email: _____

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

☐ **All Dates** ☐ **From Date:** _____ **To Date:** _____

☐ Verbal Communication
☐ Progress Notes
☐ X-rays
☐ X-ray Report
☐ MRI
☐ MRI Report
☐ EKG Results
☐ Letters/Correspondence
☐ Diagnostic Test Results
☐ Laboratory Report
☐ Colonoscopy Results
☐ Pap Test Results
☐ Mammogram Results
☐ Immunization Records
☐ AODA/SUD Notes
☐ AODA/SUD Assessment
☐ BH Diagnostic Assessment
☐ Mental Health/Psychotherapy Notes
☐ Other, please specify:_____

DENTAL ONLY:
☐ Dental Progress Notes
☐ Dental Treatment Plan
☐ Dental X-rays
☐ Dental TX Completed

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 below box is checked.

☐ **Do not release my information regarding:** _____

- The expiration date of this authorization is one year.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I can do so in writing or orally. However, it is highly recommended to send a written revocation to the medical records department. The revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- 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. 42 CFR Part 2 and/or HIPAA 45 CFR prohibits further re-disclosure of records related to substance abuse.
- 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 **Date**

_____ _____ _____
Signature of parent or authorized representative signature **Relationship** **Date**

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