1. Patient Information	**NAME** _____ Office Use Only MNR _____ Date of Birth _____ Day Phone _____ Email _____
2. Health Care Provider or Clinic who has information you want released?	**NAME/ORGANIZATION** _____ Phone _____ Address _____ Fax _____ City _____ State _____ Zip _____
3. Where do you want the information to be sent?	**NAME/ORGANIZATION** _____ Phone _____ Address _____ Fax _____ City _____ State _____ Zip _____
4. Why is it needed?	☐ Continuity of Care ☐ Workers' Compensation* ☐ School ☐ Personal use* ☐ Insurance application* ☐ Insurance payment/claim* ☐ Legal* ☐ Other _____
5. What are the approximate dates of information you want released? **What** do you want released?	☐ **All Dates** ☐ **Service Dates Between** _____ **to** _____ ☐ Verbal Communication ☐ Letters/Correspondence ☐ AODA/SUD Notes/Assessments ☐ Progress Notes ☐ Pap/Mammogram Results ☐ BH Notes/Assessments ☐ Imaging ☐ Colonoscopy Results ☐ Dental Progress Notes ☐ EKG Results ☐ Immunization Records ☐ Dental Treatment Plans ☐ Laboratory Report ☐ Hospitalization/ER ☐ Dental Imaging ☐ Chiropractic ☐ Other (specify content and dates) _____ My health information being released <u>may include</u> information related to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and alcohol or drug abuse and dependence <u>unless the below box is checked</u>. ☐ Do not release my information regarding: _____
6. When are these records needed?	**Date** the information is needed. ____ / ____ / ____ Or **Date of the appointment?** ____ / ____ / ____
7. How do you want to receive these records?	**Release Method:** ☐ Mail ☐ Fax ☐ Pick Up (Please bring a photo ID)

- This authorization lasts for one year after the date you sign it unless you enter a different expiration date here: _____
- I understand I have the 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.
- I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. 42 CFR Part 2 and/or HIPAA 45 CFR prohibits further re-disclosure of records related to substance abuse.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time to the extent that the program or person which is to make the disclosure has already acted in reliance on it.
- I understand that Lake Superior Community Health Center may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.293, WI Administrative Code HHS117, NDCC 23-12-14, Federal Rule 45 CFR 164.524; Charges may apply. I may be required to pay a fee for retrieval and photocopying of records and /or supervising inspection of medical/dental records. *
- I understand a photocopy or fax of this form is the same as the original.

8. Patient **Signature** and **Date** are required to release records. If an **Authorized Person** is signing you must include legal **documentation.**	_____ *Patient Signature* _____ *Date*	_____ *Signature of Authorized Person* ☐ Parent of Minor ☐ Court-appointed Guardian/conservator (**Include legal documentation)** _____ *Date*

Email: ROI@lschc.org	**Mail to:** LSCHC – HIS 4325 Grand Ave. Duluth, MN 55807	**Telephone Number:** (218) 727-1497	**Fax Number:** (218) 722-2468