



St. Michael's
 HOSPITAL & NURSING HOME
 HOSPICE/HOMECARE
 LAKESHORE ESTATES
Touching Peoples' Lives Every Day

**AUTHORIZATION FOR
 DISCLOSURE OF
 HEALTH INFORMATION**

425 North Elm Street
 Sauk Centre, MN 56378
 Phone: (320) 352-2221
 Fax: (320) 351-1740

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ SSN: _____

Yes No Is the patient their own guardian? If not, who is responsible? _____

SEND INFORMATION TO: (please be specific)

Provider Name: _____

Address: _____

Telephone #: _____ Fax #: _____

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name: _____ St. Michael's Hospital and C&NC

Address: _____ 425 Elm Street North

_____ Sauk Centre, MN 56378

Telephone #: (320) 352-2221 Fax #: (320) 351-1740

PURPOSE OF DISCLOSURE: (must complete) Transfer of Care Self Specialist Other _____

IDENTIFY INFORMATION TO BE DISCLOSED BELOW: Dates of treatment: _____ to _____

- | | |
|--|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Radiology/Laboratory/Pathology Reports |
| <input type="checkbox"/> Inpatient Records | <input type="checkbox"/> Photographs, videotapes, digital or other images |
| <input type="checkbox"/> Outpatient/Emergency Room Reports | <input type="checkbox"/> Other: _____ |

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This authorization shall be in force and effective for 1 year at which time this authorization expires. This authorization may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996. The use or disclosure requested under this authorization will result in direct or indirect remuneration to St. Michael's from a third party. (if applicable) A copy of this form is to be treated as the original.

 Date Signature of Patient or Legal Representative Relationship to Patient

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information related to the testing, diagnosis, or treatment for:

- | | |
|--|--|
| <input type="checkbox"/> HIV/AIDS Virus | <input type="checkbox"/> Mental Health/Psychiatric Disorders |
| <input type="checkbox"/> Sexually Transmitted diseases | <input type="checkbox"/> Drug, Alcohol Abuse/Treatment |

 Date Signature of Patient or Legal Representative Relationship to Patient

For Facility Use: Date Received: _____ Date Information Released: _____ Chart #: _____ Person/Department Sending Records: _____
