Pipestone County Medical Center & Family Clinic
Avera

PI.Consent

916 4th Avenue Southwest
Pipestone, Minnesota 56164-
(507)825-5811

Pt. Acct Sticker Here

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

RE: _____ Address: _____

Birthdate: _____ _____

Contact Person: _____ **Daytime Phone:** _____

This will authorize Pipestone County Medical Center to release to:

_____
(Name/Title of Person/ Organization and Address)

information from the medical records maintained while I was a patient at Pipestone County Medical Center from _____ to _____
(Date)

Information To Be Disclosed Is:

_____	Discharge Summary	_____	Operative Reports
_____	Consultation Reports	_____	Pathology Reports
_____	History and Physical Exam	_____	X-Ray Reports
_____	Laboratory Reports	_____	Financial Disclosure
_____	Other (Specify) _____		

The information is needed for the following purpose(s): □ Continued Healthcare □ Completion/payment □ Other

_____

_____ I agree and understand that the information in my health record to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

1. I understand I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand 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 as the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date I signed it.

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer.

X _____ Date _____
(Signature of Patient or guardian)