



820 2nd Avenue
P.O. Box 338
Windom, MN 56101
(507) 831-1703

Release Information to (circle appropriate provider):

Rod Dynes, MD
Mary Olson, MD
Jessica Kelley, NP

Patient Identification	Patient Name: _____ Date of Birth: _____ Address: _____ City/State/Zip: _____ (Maiden/Previous Names/Nickname): _____ Social Security Number: _____
Provider (Who is releasing information?)	The following individual or organization is authorized to make the disclosure: Provider Name: <u>Avera United Medical Clinic</u> Fax: <u>507-831-4170</u> Address: <u>820 2nd Ave. PO Box 338</u> Phone: <u>507-831-1703</u> City/State/Zip: <u>Windom, MN 56101</u>
Disclose Information to: (Where is information to be sent?)	Name/Facility: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
Information to be Disclosed	<input type="checkbox"/> Standard Chart Copy (Includes Demographic Face Sheet, Physician Dictated Reports, All Test Results) <input type="checkbox"/> Entire Record <input type="checkbox"/> Other _____ <input type="checkbox"/> History and Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Lab <input type="checkbox"/> X-ray and imaging reports <input type="checkbox"/> EKG <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report
Service Dates	Dates of service from (date) _____ to (date) _____
Purpose of Disclosure	<input type="checkbox"/> Continued Healthcare <input type="checkbox"/> Completion/Payment <input type="checkbox"/> Personal <input type="checkbox"/> Other _____ (Purpose not required for personal requests) A copying fee may be charged on requests for purposes other than patient care.
Expiration Date	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 shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.
Revocation	I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to: <ul style="list-style-type: none"> • Information already released in response to this authorization • My insurance company when the law provides my insurer with the right to contest a claim under my policy.
Authorization	I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand 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 Avera McKennan Privacy Officer at (605) 322-7801. _____ Signature of Patient or Legal Representative Date _____ If Signed by Legal Representative, Relationship to Patient Signature of Witness Date: _____ Information sent: _____