Avera Marshall Regional Medical Center
300 S. Bruce St.
Marshall, MN 56258
507-532-9661

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____

(PLEASE PRINT)

PHONE # REQUESTER CAN BE REACHED AT: _____

AUTHORIZE: (Who has information you would like released?)

_____
Name

_____
Street Address

_____ _____ _____
City State Zip

TO DISCLOSE TO: (To whom should the information be sent?)

_____
Name

_____
Street Address

_____ _____ _____
City State Zip

INFORMATION TO BE DISCLOSED:

I need by:

_____
Date

I will pick up by:

_____
Date

MEDICAL RECORD RELEASE

Records concerning: _____ Dates of Service: _____
(specific diagnosis or treatment)

____ History & Physical
____ Consultation Reports
____ X-ray
____ Reports
____ Films
____ Other (specify) _____
____ Discharge Summary
____ Pathology Report
Progress Notes
____ Physician's
____ Nurse's
____ Operative Record
____ Lab Reports
____ ER Record
____ Therapy Record

ALL RECORDS PERTAINING TO SEXUALLY TRANSMITTED DISEASE, MENTAL HEALTH, CHEMICAL DEPENDENCE/ABUSE AND/OR HIV/AIDS RELATED ILLNESS WILL BE RELEASED UNLESS OTHERWISE INDICATED HERE IN WRITING:

_____

_____

PURPOSE FOR THE DISCLOSURE:

____ Further Medical Care
____ Inspection of Health Care Records
____ Disability Determination
____ Payment of Ins. Claim
____ Out of Town Move
____ Other _____
____ Legal Investigation
____ Personal

This authorization will remain in effect for 12 months from the date of signature and may be canceled by me in writing at any time. I understand that I may inspect or copy the information to be disclosed. I understand that once this information is released, it may be subject to re-disclosure by the recipient and no longer be protected by the federal privacy law. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I authorize release of my medical records in accordance with the specifications listed above.

Signature of Patient _____ Date _____
(If signed by person other than patient, state relationship to patient)

Patient is: ____ Minor ____ Incompetent ____ Unable to Sign ____ Disabled ____ Deceased
Legal Authority: ____ Parent of Minor ____ Legal Guardian ____ Next of Kin of Deceased or Personal Representative

Request Completed By: _____ Date: _____

DIR:Release of Medical Information