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**MADÉLIA COMMUNITY HOSPITAL**  
 121 DREW AVE. S.E.  
 MADÉLIA, MN 56062

**Authorization for Disclosure of Personal Health Information**

<b>Patient Identification</b>	Name: _____ Date of Birth: _____ Address: _____ Phone Number _____ City/State/Zip: _____ Maiden/Previous Names/Nickname: _____
<b>Provider (Who is releasing Information?)</b>	Provider/Facility Name: <u>Mayo Clinic Health System - Madelia</u> Address: <u>115 Drew Ave. SE</u> City/State/Zip: <u>Madelia, MN 56062</u> Phone Number: <u>507-642-3241</u>
<b>Disclose Information To: (Where is information to be sent?)</b>	Name/Facility: <u>Madelia Community Hospital - Health Information Department</u> Address: <u>121 Drew Ave. SE</u> City/State/Zip: <u>Madelia, MN 56062</u> Phone Number: <u>507-642-3255</u> Fax: <u>507-642-8010</u>
<b>Information to be Disclosed</b>	<input type="checkbox"/> Hospital Progress Notes <input type="checkbox"/> History & Physical <input type="checkbox"/> Pathology Report <input type="checkbox"/> EKG/Cardiology Reports <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Physical Therapy Notes <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Operative Report <input type="checkbox"/> Outpatient Information <input type="checkbox"/> ER Records <input type="checkbox"/> Lab Data <input type="checkbox"/> Consultation <input type="checkbox"/> Clinic Notes <input type="checkbox"/> All Records <input type="checkbox"/> Other (Specify)
<b>Service Dates</b>	Time period from: _____ to _____ Concerning: _____ (specific diagnosis or treatment, auto accident, etc.)
<b>Purpose of Disclosure</b>	<input checked="" type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Consult/Second Opinion <input type="checkbox"/> Out of town move <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other (Specify)
<b>Expiration Date</b>	This authorization will expire one year from the date of signature or on _____
<b>Revocation</b>	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.
<b>Authorization</b>	I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To", I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.  _____ Signature of patient/representative      _____ Signature Date _____ (Relationship to patient, if signed by representative)      _____ (Reason patient unable to sign)      _____ (Witness – optional)  Please supply proof of authority to act. For minors, proof only required if other than parent.
<b>Internal Use Only:</b>	MR #: _____ Disposition Info needed by: _____ Authorization Received: _____ Date sent: _____ Sent by: _____ (date) <input type="checkbox"/> Authority to act attached <input type="checkbox"/> ID Validated