Family Practice Medical Center
502 SW 2nd St, Suite 1 Willmar, MN 56201
Phone: 320-235-7232
Fax: 320-231-8602

Authorization for Release of Information

_____ _____ _____
Patient's Full Name | Patient's Date of Birth | Patient's Social Security Number

_____ _____ _____
Patients Telephone Number | Patient's Email Address

I hereby authorize use or disclosure of protected health information about me as described below.

The following person or facility is authorized to use or disclose information about me:

_____

The following person (or class of persons) may receive disclosure of protected health information about me. (include facility name, address, telephone number and fax number):

_____

_____

Reason for needing records: _____ Date Needed ___/___/____

Please send records via:

☐ Mail ☐ Patient will pick up ☐ Fax to: (____)_____ ☐ E-mail: _____

Information to be released:

___ Discharge Summary ___/___/____
___ History and Physical ___/___/____
___ ICC form ___/___/____
___ Progress Notes ___/___/____ to ___/___/____
___ Immunization Records
___ Operative Report ___/___/____
___ Lab reports ___/___/____
___ Imaging ___/___/____
___ All records (last 2 years)
___ Other _____

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS, or Mental Health (such as information regarding depression, counseling, etc) will be disclosed.

YES, disclose this information * _____

FPMC will not retain a permanent copy of records received from other facilities. After review, the received records will be securely disposed of. Please sign here if you want these records forwarded to you

YES, forward my transferred records to me after they have been reviewed * _____

I understand that:

- I may refuse to sign the authorization and that FPMC will not condition treatment or payment on my providing this authorization
- the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying Family Practice Medical Center - Medical Records department, in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- This authorization automatically expires 1 year from signature date **OR** upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____
- Federal and state laws permit a fee to be charged for the copying of patient records. FPMC has contracted with HealthPort to make copies. **You may be required to pre- pay for copies of >100 pages.**

_____ _____ _____
Signature of Individual or Authorized Legal Representative | Relationship | Date