# Release of Information

**Patient Name:** _____ **DOB:** _____

**Records released to:**

Name/Organization_____

Address _____

City/State/Zip _____

Fax # _____

**Records released from:**

Johnson Memorial Health Services

1282 Walnut Street
Dawson MN 56232
P: 320-769-4323
F: 320-769-4576

**The information is to be released for the following purpose:**

_____ Continuing Care _____ At the request of the patient _____ Other (specify)

_____ Verbal communication regarding any & all of my healthcare _____

**Specific protected health information to be released includes:**

_____ History & Physical _____ Discharge Summary _____ Operative Report

_____ Pathology Report _____ Outreach Report _____ Lab Report

_____ XR Report _____ Provider/Progress Notes _____ Other (Specify)

_____ Entire Record _____

**Date(s) of service:** _____

I understand the information in my health record may include information related 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 or drug abuse.

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 any 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 six months from the date I sign it.

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 by 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 the disclosure of my health information, I can contact the privacy officer.

**Signature** _____ **Date** _____

**Relationship to patient** _____ **Witness** _____

***Provide appropriate documentation evidencing the Representative's authority to act for the patient (for example, a valid Healthcare Power of Attorney or Health Care Directive).***