LifeCare Medical Center

715 Delmore Drive, Roseau, MN 56751 Phone (218) 463-2500; Fax (218) 463-4307

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____Previous name(s):_____

Address:_____City/State/Zip:_____

Telephone:_____ Date of Birth:_____

I authorize:

☐ LifeCare Medical Center

_____

_____

To Release to:

_____

_____

_____

How would you like to receive your records?

☐ **Fax** - Fax#: _____ ☐ **Mail** ☐ **Pick up** on Date: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED
(last 5 years unless specified)

☐ History & Physical	☐ Radiology Report	☐ Procedure Report	☐ HIV or AIDS
☐ Discharge Summary	☐ Radiology Images	☐ Behavioral Health Records	
☐ Operative Report	☐ Lab Reports	☐ PT/OT/Rehab Records	
☐ Progress Notes	☐ Emergency Room Record	☐ Billing Information	☐ Other_____

Pertaining to Treatment Dates: _____

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program ☐ Psychotherapy notes (this consent cannot be combined with any other)

PURPOSE OF THE USE AND DISCLOSURE

☐ Further Treatment (Date of Appt._____) ☐ Personal use ☐ Disability determination

☐ Insurance application/payment of insurance claims ☐ Legal ☐ Other: _____

I understand that by signing this form, I am requesting that the specific health information be sent to the third party listed above.

I may stop this authorization at any time by writing to LifeCare Medical Center. If LifeCare Medical Center has already released health information based on my authorization, my request to stop will not work for that health information.
I understand that information disclosed under this authorization may be re-disclosed by the person or organization to which it is sent, and it may no longer be protected by federal or state privacy laws.
I understand that if the organization to receive this information is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

A photocopy or fax of this authorization will be treated in the same manner as the original.

This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:
Date: _____ or specific event: _____

_____ _____
Signature of Patient/Guardian/Representative Date

MRN:_____ Release Completed ☐ Completed By/Date: _____