Sawtooth Mountain Clinic
Together Through Life
a 501©(3) not-for-profit organization
513 5th Ave West   Grand Marais, MN 55604
Phone: 218-387-2330   Fax: 218-387-1278

________________________________ (Patient's Legal Name and date of birth)
________________________________ (Patient's Mailing Address)
________________________________ (Patient's Mailing Address)

Authorization for Family Member or Appointed Person

To discuss patient care and/or receive documentation for patient care from provider and/or staff member at Sawtooth Mountain Clinic for purposes of care coordination

I authorize my Protected Health Information to be released to:

____ Relationship to Patient ____________
____ Relationship to Patient ____________
____ Relationship to Patient ____________
____ Relationship to Patient ____________

The individual(s) named above is/are authorized to obtain information in the following manner:

- Verbally: for example, via phone call or in person (face to face)
- Written, printed, or electronic format: for example, medical record copies, portal communication, or appointment/referral information
- Other (please indicate) ____

__ This authorizes the above-named individual(s) to obtain unlimited health information

__ This authorized the above-named individual(s) to obtain health information pertaining to these limited conditions: ____

__ This authorizes the above-named individual(s) to accompany this patient to appointments and authorize treatment.

I understand the information to be released may include my past, present or future health information. I may revoke this authorization at any time. This authorization will not expire unless revoked by myself or my legal representative, upon notification of death, or at the age of 18. I understand that information disclosed pursuant to this authorization might be disclosed by the recipient and may no longer be protected by HIPPA.

____ ____________

Patient Signature Date

____ ________________________

Authorized Person's Signature (if patient unable to sign) Relationship/Authority