Sawtooth Mountain Clinic, Inc. **Phone: 218-387-2330**
513 5th Ave. W, Grand Marais, MN 55604 **Fax: 218-387-1278**

AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____, _____, _____
Patient Name: LAST FIRST MI Date of Birth Medical Record Number

I, Hereby Authorize:
(Name and Address of releasing facility)
_____
_____
_____

To Release Information To:
(Name and Address of Individual, facility/organization)
_____
_____
_____

NOTE: **No two-sided copies accepted due to increased chance of error in scanning and reconciling. Thank you!**

All information regarding Alcohol and/or Drug Abuse or Behavioral Health, HIV or Sickle Cell Anemia will be released **unless you restrict** by initialing below:
_____ Do not release Alcohol and/or Drug Abuse information
_____ Do not release Behavioral Health information
_____ Do not release HIV related information
_____ Do not release Sickle Cell Anemia information

PURPOSE OF DISCLOSURE:
( ) Payment of Claim
( ) Continuation of Care
( ) Legal Release
( ) School
( ) Worker's Compensation
( ) For Personal Use
( ) Other (specify): _____

INFORMATION TO BE RELEASED: Between Dates of: _____ to _____

( ) Diagnostic Test Reports	( ) Discharge Summary	( ) Procedure Reports
( ) Provider/Progress Notes	( ) H&P Exam/Initial Evaluation	( ) Immunization Records
( ) X-ray Reports	( ) HIV related information	( ) Correspondence
( ) Laboratory Reports	( ) Exchange of Verbal Communication	( ) Orders
( ) Psychological Testing	( ) Transfer/Outside Information	( ) Consult
( ) Other (Specify content & dates): _____		( ) Completed Form

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is ____ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization sat any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that SMC may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand that in compliance with MN Statute 144.335, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as the original.

I understand that this authorization will remain in effect 1 year from the date of signature. I also understand that it may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith.

If I am signing as Authorized Representative of the patient, I am:
□ Parent of minor □ Court appointed guardian/conservator

_____ _____
Signature or mark of patient, parent of minor, or legal guardian/estate representative Date

_____ _____
Witness signature required if patient unable to sign but uses X or a mark OR Date

If patient is unable to sign, the person signing the authorization will be required to show proof of guardianship, or other authority and relationship to patient allowing him/her to authorize the release of medical information.
All sections of this authorization must be completed for the release of medical information. Incomplete authorizations will not be accepted. Please see the reverse of this form for authorization standards. *forms:medrlse 8/14*

Authorization Standards

Patient authorizations for the release of information must be in writing and contain the following elements:

1. The name of the facility or physician who is to make the disclosure.

2. The name or title of the person or organization to which the disclosure is to be made.

3. The name of the patient.

4. The purpose or need for the disclosure.

5. The extent or nature of information to be disclosed.

6. A statement that the consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, and a specification of the date, event, or condition upon which it will expire without express revocation.

7. The date on which the consent is signed.

8. The signature of the patient, or when required under law, the signature of the person authorized to give consent (i.e. for minors), or the signature of the person authorized to sign in lieu of the patient (i.e. when patient is unable to sign).

The Release of records or information may be subject to a charge.