Sawtooth Mountain Clinic

Together Through Life
a 501(c)(3) not-for-profit organization

Authorization for Family Member or Appointed Person to Discuss Patient Care and/or Receive Documentation of Patient Care from Provider and/or Staff Member of SMC for Purposes of Care Coordination.

Patient Name:_____ Date of Birth: _____
Release Information To: (must be 18 years of age or older)

_____Relationship to Patient**:** _____

_____Relationship to Patient**:** _____

_____Relationship to Patient**:** _____

_____Relationship to Patient**:** _____

The individual named above is authorized to obtain information in the following manner:

- Verbally: for example, via phone call or in person (face to face)
- Written or printed format: for example, medical record copies or appointment/referral information
- **Comment:**_____

☐ This authorizes the above named individuals to obtain unlimited health information

☐ This authorizes the above named individual to obtain health information pertaining to these limited conditions: _____

_____

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 or upon notification of death. I understand that information disclosed pursuant to this authorization might be disclosed by the recipient and may no longer be protected by HIPAA.

_____ _____
Patient Signature Date

_____ _____
Authorized Person's Signature (if patient unable to sign) Authorized Person's Authority To Sign (Parent, Guardian, Power of Attorney, Etc.)

_____
Date

513 5th Ave. W, Grand Marais, MN 55604 Phone 218-387-2330 Fax: 218-387-1278