North Shore HEALTH
COOK COUNTY | MINNESOTA
515 W 5TH AVE
GRAND MARAIS, MN 55604-3017
(218) 387-3040

AUTHORIZATION FOR USE AND DISCLOSURE

Patient Name: LAST_____ FIRST_____ MI _____ DOB _____

I authorize release from: _____
(Individual name, facility/organization and address)

To release information to: _____
(Individual name, facility/organization and address)

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

INFORMATION TO BE RELEASED: Between Dates of: _____ and_____

( ) Discharge Summary _____
( ) H&P Exam/Initial Evaluation _____
( ) Diagnostic Test Reports _____
( ) Progress Notes/Provider Notes _____
( ) Orders _____
( ) Emergency Department _____
( ) Other (Specify content/dates):

( ) X-Ray Reports _____
( ) X-Ray Films/MRI _____
( ) Procedure Reports _____
( ) Lab Reports/Pathology _____
( ) Correspondence _____
( ) Itemized Billing Statement _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

I understand the expiration date of this authorization is one year after the date signed.
I understand that I may revoke this authorization at 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.
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 by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
I understand that in compliance with MN Statute 144.292 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.

_____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date