

***Authorization for Release of
Medical Information***

Patient

First

Middle

Last

MR # _____

Previous Name

Date of Birth

____/____/____

Phone number

____-____-____

Information to be:

Mailed Picked-up Faxed

Date needed by:

____/____/____

Release Information To:

Name

Dulcimer Medical Center, P.A.

Phone number

507-238-4968

Fax number

507-238-1533

Address – Street

717 S. State Street - Suite 800

City

Fairmont

State

MN

ZIP

56031

Information to be Disclosed

Physician progress notes for two years

Preventative Health Flow sheet

Immunization Records

Current Medication Lists

Lab reports last 2 years

EKG reports

Radiology reports/mammogram reports

Psychiatry notes for two years

Hospital history and physical exams

Hospital discharge summaries

Operative notes

Pathology reports

Consultations

I understand that I may revoke this consent at any time, but that such a revocation will only be effective upon written notice to Dulcimer Medical Center. I do not authorize re-disclosure of this information to anyone, but understand that in the event there is an unauthorized disclosure by the recipient of this information, the protected health information is no longer protected by Federal Privacy Guidelines. This authorization will automatically expire one year from the date of my signature.

Reason for disclosure: Further care

Authorization Signature (Any patient 18 or older, must sign for themselves. If signed by a person other than patient, state relationship and authority below.)

X _____

Date: ____/____/____

Patient is

Minor Incompetent Disabled

Legal Authority

Legal guardian Healthcare POA

Parent of minor (my signature certifies my parental rights have not been terminated.)

For Office Use Only

Information given sent to patient representative by:

Date:

____/____/____