

**Authorization for Release of
Medical Information**

Patient

MR # _____

Name – First _____ Middle _____ Last _____ Previous Name _____
Address- _____

City _____ **State** _____ **Zip** _____

Date of Birth ____/____/____ **Phone number** ____-____-____ **Information to be:** ____Mailed ____Picked-up ____Faxed **Date needed by:** ____/____/____

Release Information From:

Release Information To:

Name Dulcimer Medical Center, P.A. **Phone number** 507-238-4968 **Fax number** 507-238-1533

Address – Street 1950 Center Creek Dr. Suite 100 **City** Fairmont **State** MN **ZIP Code** 56031

Information to be Disclosed

Physician progress notes for two years	Psychiatry notes for two years
Preventative Health Flow sheet	Hospital history and physical exams
Immunization Records	Hospital discharge summaries
Current Medication Lists	Operative notes
Lab reports last 2 years	Pathology reports
EKG reports	Consultations
Radiology reports/mammogram reports	

Reason for disclosure: Further care

Authorization

I understand Dulcimer Medical Center cannot condition treatment based on my signing or not signing this authorization.

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.

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

X _____
Patient is _____ Legal Authority _____
__Minor __Incompetent __Disabled __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:** _____

