

LifeCare Medical Center
Health Information Department
715 Delmore Drive Roseau MN 56751
(218) 463-2500 Fax (218) 463-4307

MR# _____

Date Completed _____

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Patient Name: _____ Maiden/former name: _____

Address: _____

Telephone _____

Date of Birth: _____

AUTHORIZATION:

I authorize:

To Release to:

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

(last 5 years unless specified)

- | | | |
|---|--|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology reports | <input type="checkbox"/> Outpatient information |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology films | <input type="checkbox"/> Behavioral Health Records |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Lab/pathology reports | <input type="checkbox"/> PT/OT/Rehab Records |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Billing Information | <input type="checkbox"/> HIV or AIDS | |

Pertaining to Treatment Dates: _____

- I authorize verbal and/or written exchange about my medical information.

PURPOSE OF THE USE AND DISCLOSURE

- | | |
|--|---|
| <input type="checkbox"/> Further Treatment (Date of Appointment _____) | <input type="checkbox"/> Personal use |
| <input type="checkbox"/> Insurance application/payment of insurance claims | <input type="checkbox"/> Disability determination |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Legal |

I understand that my records may contain information regarding drug, alcohol, psychological or psychiatric conditions and communicable diseases are protected by Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless other provided in the federal regulations.

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been in reliance on it. This authorization shall be valid for 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

Signature of Patient/Guardian/Representative
MedRec/Forms/ROI Form

Date