505 12th Ave. W., Virginia, MN 55792
PHONE: 218-780-9499 FAX: 218-389-7891

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient Name Date of Birth

AUTHORIZATION
I herby authorize:
Northern Reflections
505 12th Ave W.
Virginia, MN 55792

TO: ☐ Release ☐ Obtain ☐ Exchange Information with:
_____
_____
_____

PURPOSE OF DISCLOSURE

☐ Continuing Care
☐ School
☐ Coordination of Care
☐ Other (Specify content and dates): _____
☐ Personal Use
☐ Legal Matter

INFORMATION TO BE RELEASED: Between the dates of: _____ to/and/present _____

☐ Discharge Summary
☐ Written Communication
☐ Oral Communication
☐ Progress Notes/Provider Notes
☐ Completed Form
☐ Diagnostic Assessment
☐ Correspondence

☐ Other (Specify): _____

ACHNOWLEDGEMENT OF UNDERSTANDING:

I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner. My health information is protected by federal (HIPAA 45 CFR, 42 CFR Part 2) and state laws and regulations, and disclosure is allowed only with my authorization, except in limited circumstances described in the facility's Notice of Privacy Practices. 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 in reliance on it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand I will receive a copy of this form upon request. I understand that in compliance with MN STATUE 144.335 I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. I understand that a photocopy or fax of this form is the same as the original.

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

_____ _____ _____
Signature of Witness Relationship Date

Disclosure of this material is prohibited by law: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.