

INTEGRACARE / WILLIAMS

100 South Second Street
P.O. Box 296
Sartell, MN 56377

CLINIC

(320) 251-2600
(320) 251-4763 Fax

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

AUTHORIZES:

_____ RELEASE PROTECTED HEALTH INFO TO:

NAME OF PROVIDER/PLAN/OTHER

_____ DISCLOSURE PROTECTED HEALTH INFO TO:

STREET ADDRESS

WILLIAMS/INTEGRACARE CLINIC
100 SOUTH 2ND STREET, PO BOX 296
SARTELL, MN 56377

CITY, STATE, ZIP CODE

DBA:
INTEGRACARE/WILLIAMS CLINIC
INTEGRACARE LTD.
WILLIAMS CHIROPRACTIC CLINIC
URGENT CARE

**INFORMATION TO BE RELEASED/DISCLOSED: (CHECK APPLICABLE CATEGORIES)
(I UNDERSTAND THAT ONLY PROTECTED HEALTH INFORMATION GENERATED BY YOUR CLINIC
CAN BE RELEASED OR DISCLOSED)**

- MEDICAL HISTORY, EXAM, REPORTS
- TREATMENT OR TESTS
- IMMUNIZATIONS
- X-RAY REPORTS
- LABORATORY REPORTS
- CONSULTATIONS

- SURGICAL REPORTS
- HOSPITAL RECORDS INCLUDING REPORTS
- ALLERGY RECORDS
- PRESCRIPTIONS
- ENTIRE RECORD
- OTHER (SPECIFY): _____

IN COMPLIANCE WITH MINNESOTA STATUTES, WHICH REQUIRE SPECIAL PERMISSION TO RELEASE OTHERWISE PRIVILEGED INFORMATION, PLEASE RELEASE RECORDS PERTAINING TO:

- MENTAL HEALTH
- ALCOHOLISM
- HIV (AIDS)
- OTHER (SPECIFY): _____
- DEVELOPMENTAL DISABILITIES
- DRUG ABUSE
- SEXUALLY TRANSMITTED DISEASES

FOR THE FOLLOWING DATE(S): _____

PURPOSE FOR NEED OF DISCLOSURE (CHECK APPLICABLE CATEGORIES)

- FURTHER MEDICAL CARE
- INSURANCE ELIGIBILITY/BENEFITS
- LEGAL INVESTIGATION OR ACTION
- PERSONAL
- CHANGING PHYSICIANS
- OTHER (SPECIFY): _____

I understand that if the person(s) and/or organizations listed on the reverse are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your Right with Respect to This Authorization

- **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed on reverse side who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. *(As a provider or Health Plan, the rule permits you to condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on the signing of this authorization in the following circumstances:*
 - (a) A health care provider may condition the provision of research-related treatment on the provision of an authorization to use and/or disclose an individual's health information for such research.*
 - (b) A health plan may condition enrollment in the health plan or eligibility for benefits on the provision of an authorization required prior to enrollment in a health plan, if:*
 - (i) the authorization is for the health plan's eligibility or enrollment determinations or for its underwriting or risk rating determination and*
 - (ii) the authorization is not for the use and/or disclosure of psychotherapy notes:*
 - (c) an entity subject to the Rule may condition the provision of health care that is solely for the purpose of creating health information for disclosure to a third party on the provision of an authorization for the disclosure of the health information to such third party.*

If you wish to make such conditions, you must include a description of these circumstances upon signing of this authorization)

- **Right to Withdraw This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Medical Records Supervisor. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed on reverse have already made in reference to this authorization.

This authorization is good for 1 year from the date signed below.

Patient Signature _____
Date
(If signed by person other than patient, state relationship and authority to do so.)

Patient is: Minor Incompetent Disabled Deceased

Legal Authority: Custodial Parent Legal Guardian Executor of Estate of Deceased
 Power of Attorney for Healthcare Authorized Legal Representative

PLEASE ATTACH LEGAL DOCUMENTATION OF LEGAL AUTHORITY