AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

AUTHORIZES:

_____ RELEASE PROTECTED HEALTH INFO TO:

WILLIAMS/INTEGRACARE CLINIC
100 SOUTH 2ND STREET, PO BOX 296   _____ DISCLOSURE PROTECTED HEALTH INFO TO:
SARTELL, MN 56377

_____

DBA: NAME OF PROVIDER/PLAN/OTHER
INTEGRACARE/WILLIAMS CLINIC
INTEGRACARE LTD.   _____
WILLIAMS CHIROPRACTIC CLINIC   STREET ADDRESS
URGENT CARE

_____

CITY,STATE,ZIP CODE

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   ___ SURGICAL REPORTS

___ TREATMENT OR TESTS   ___ HOSPITAL RECORDS INCLUDING REPORTS

___ IMMUNIZATIONS   ___ ALLERGY RECORDS

___ X-RAY REPORTS   ___ PRESCRIPTIONS

___ LABORATORY REPORTS   ___ ENTIRE RECORD

___ CONSULTATIONS   ___ OTHER (SPECIFY):_____

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

___ MENTAL HEALTH   ___ DEVELOPMENTAL DISABILITIES

___ ALCOHOLISM   ___ DRUG ABUSE

___ HIV (AIDS)   ___ SEXUALLY TRANSMITTED DISEASES

___ OTHER (SPECIFY) _____

FOR THE FOLLOWING DATE(S): _____

PURPOSE FOR NEED OF DISCLOSURE (CHECK APPLICABLE CATEGORIES)

___ FURTHER MEDICAL CARE   ___ PERSONAL

___ INSURANCE ELGIBILITY/BENEFITS   ___ CHANGING PHYSICIANS

___ LEGAL INVESTIGATION OR ACTON   ___ OTHER (SPECIFY): _____

I understand that if the person(s) and/or organizations listed above 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 above 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 singing 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 if 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 Supervisior. 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 above 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 a person other than the 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