Brainerd Medical Center, P.A.
2024 South Sixth Street, Brainerd, Minnesota, 56401-4529
218-828-7100 Fax 218-828-2886

Authorization for the Use or Disclosure / Release of Protected Health Information

I authorize **Brainerd Medical Center, P.A**. (**BMC**) to use and disclose **Protected Health Information** (**PHI**) subject to the specifications listed below.

____**Disclose/Release to:**

____**Obtain from**:

Organization: _____

Address: _____

City/State / Zip_____

Patient's Name: _____**DOB:** _____**SSN:** _____
Please Print

Address: _____**City/State** _____**Zip**_____

Dates of Service: _____ **Phone (____)** _____

Request:
___Progress Notes
___Immunization Records
___Worker's Compensation Records
___Laboratory Results
___Xray Films
___Xray Reports
___EKG's
___Other _____

For:
___ Personal Use
___ Moving Elsewhere
___ Insurance Reasons
___ Changing Providers
___ Consultation Elsewhere
___ Legal/Litigation
___ Worker's Comp
___ Other_____

BMC Chart # _____ - ____

Specific Release Required

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavior or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the organization(s) or individual(s) listed above.

Signature _____

A faxed copy or photocopy of this unaltered authorization is allowed. This authorization expires when this request has been completed **or** on _____. I understand that if I extend the time period, I have the right to revoke this authorization in writing, but that any released PHI would be exempt from the revocation. I recognize that the PHI used or disclosed may be re-disclosed by the recipient and no longer be protected by Federal Privacy standards. PHI in your chart not generated by BMC will not be released to another facility.

I understand that I have the right to have a copy of this authorization and to inspect or copy the health information that I have authorized to be used or disclosed. I also understand that I do not have to sign this form and that the person and or organization listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to not sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorization disclosure. Since authorization is needed to release information to payers for certain mental health services and HIV testing, if I refuse to sign this form for this purpose, I understand I will be responsible for paying the entire bill for these services).

I have reviewed and understand this authorization. By signing this form, I acknowledge that it is accurate and reflects my wishes.

_____ _____ _____
Signature of Patient / Legal Representative* Date Witness

* __Parent __Guardian __POA of HealthCare __Executor or Personal Representative of deceased patient

RINC # _____