



Authorization Form to Release Health Information

Human Services

PO Box 67 Jackson, MN 56143
(507) 847-4000

or

PO Box 9, Windom, MN 56101
(507) 831-1891

Public Health

402 White St, Ste 201, Jackson, MN 56143 or 235 9th Avenue, Windom, MN 56101
(507) 847-2366 • (800) 622-5207 (507) 831-1987 • (800) 247-1401

Section 1: Patient Information

Patient Name (First, MI, Last):	Patient Date of Birth:	Request Date:
Patient Address	City, State, Zip	
Daytime Phone:	Evening Phone:	

Section 2: Healthcare Organization Releasing and Receiving Information

Information Released From:	Des Moines Valley Health and Human Services 407 5th St Jackson, MN 56143	Information Released To:	Organization Name and/or Person First and Last Name Mailing Address: City, State, Zip: Phone Number: Fax Number : Date Needed By:
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Section 3: Information to be Released

Method of Disclosures
 Oral
 Written
 Electronic: Specify: _____
 Specific Dates or Years of Treatment: _____
 Any and All Information (Entire Medical Record)
 Treatment Visit Notes
 Health History Form

The Following information requires special consent by law. Even if you indicate Any and All Information, you must specifically request the following information in order for it to be released:

Chemical Dependency Program
 Psychotherapy Notes

Section 4: Reason for Release of Information

Patient's Request
 Review of patient's current care
 Treatment/continued care
 Payment
 Insurance Application
 Legal
 Appeal denial of Social Security Disability income or benefits
 Marketing Purposes (payment or compensation involved?) Yes or No. If yes, How much _____
 Sale (Payment or compensation to entity maintain the information?) Yes or No. If yes, How much _____
 Other (Please Explain) _____

Section 5: Rights under the Restriction

I understand that by signing this form, I am requesting that the health information specified in Section 3 be sent to the third party named in section 2.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 2.

If the organization, facility or professional named in section 2 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 3 is sent to the third party named in section 2, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 3 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 2 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This consent will expire one year (12 Months) from the date the form is signed unless I indicate an earlier date or ever here:

Date: _____ (MM/DD/YYYY) Or Specific Event: _____

Section 6: Patient's Signature

Patient's Signature

OR

Date (MM/DD/YYYY)

Legal Authorization Representative Signature

Date (MM/DD/YYYY)

Relationship to Patient (parent, guardian, ect) _____