

# Winneshiek Medical Center

901 Montgomery Street • Decorah, Iowa 52101 • 563-382-2911

Instructions: Please complete form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. The release is not valid without signature and date signed by patient, guardian, or legal representative.

**I hereby authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:**

Winneshiek Medical Center  
901 Montgomery Street  
Decorah, IA 52101

\_\_\_\_\_  
Facility/Person  
\_\_\_\_\_  
Address

**To disclose the following information from the health records of:**

Name: \_\_\_\_\_  
Last First MI Previous Name  
\_\_\_\_\_  
Birth Date Social Security # H Telephone #s W \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

**This information is to be disclosed to:**

\_\_\_\_\_  
Facility/Person  
\_\_\_\_\_  
Address

Winneshiek Medical Center  
901 Montgomery Street  
Decorah, IA 52101

**Covering the periods of healthcare (Date(s) of service):**

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

**My protected health information will be used or disclosed upon request for the following purposes:**

**The following information may be released:**

- |   |   |
|---|---|
| <input type="checkbox"/> Medical Summary              | <input type="checkbox"/> Photographs, videotapes, digital or other images |
| <input type="checkbox"/> Discharge Summary            | <input type="checkbox"/> Rehabilitation Documentation                     |
| <input type="checkbox"/> Operative Report Examination | <input type="checkbox"/> X-ray Reports                                    |
| <input type="checkbox"/> History & Physical           | <input type="checkbox"/> Progress Notes                                   |
| <input type="checkbox"/> Emergency Room Report        | <input type="checkbox"/> Clinic Notes                                     |
| <input type="checkbox"/> Consultation Reports         | <input type="checkbox"/> Billing Records                                  |
| <input type="checkbox"/> Laboratory Tests             | <input type="checkbox"/> Other: _____                                     |
| <input type="checkbox"/> Pathology Reports            |   |

I acknowledge that records to be released may include information that is protected by Federal and/or State Law. I Specifically authorize the release of confidential information relating to: {Place an "X" in ALL applicable boxes:}

- AIDS/HIV/sexually transmitted diseases  
 Behavioral health services/psychiatric care  
 Treatment for alcohol and/or drug abuse

**\*AUTH RELEASE\***

## Authorization to Release Patient Information

MR#: \_\_\_\_\_

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I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing either on the revocation form we provide or in letter form. The revocation will take effect on the day it is received. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

This authorization expires on \_\_\_\_\_ (Date) or upon discontinuation of treatment for current illnesses. If no date is specified, this authorization will expire one year from the date of signature.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Winneshiek Medical Center, nor will it affect my eligibility for benefits.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. § 164.524).

## Affirmation of Release

I give Winneshiek Medical Center or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have explained. All health information requested during the time period stated above may be released with this specific authorization. Copies of the records may be obtained with reasonable notice and payment of copying cost. I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Patient/Guardian/Legal Representative

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness

## Medical Center use only:

Date Sent \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Number of pages sent \_\_\_\_\_

Identification verified by \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Method:

- Picture ID
- Personally know individual

# Authorization to Release Patient Information

MR#: \_\_\_\_\_