

Saint Mary's University of Minnesota
Authorization to Disclose Health Information

Name: _____

Date of birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

_____ Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

___ Enrollment

___ Payment

___ Claims adjudication

___ Case or medical management records including:

___ Problem(s) from (date) _____ to (date) _____

___ Medication(s) [list] from (date) _____ to (date) _____

___ Most recent history and physical

___ Most recent discharge summary

___ Laboratory results from (date) _____ to (date) _____

___ X-ray and imaging reports from (date) _____ to (date) _____

___ Consultation reports from (doctors' names) _____

___ Entire record from (date) _____ to (date) _____

Other _____

4. This information may be disclosed to and used by the following individual or organization:

_____ Address: _____ for the purpose of: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Paul Wildenborg. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If no expiration date, event, or condition is specified, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Paul Wildenborg.

Signature of employee, plan participant, or legal representative:

_____ Date _____

If signed by legal representative, authority to act for employee/plan participant: _____

Witness