www.gatewayclinic.com

Patient Authorization to Use or Disclose Protected Health Information

Patient Name_____ Maiden/Former Name_____
Street Address_____ City_____ State_____ Zip_____
Date of Birth_____ Phone Number_____

INFORMATION RELEASED FROM (Name and address of releasing facility)	**INFORMATION RELEASED TO** (Name and address of receiving person/facility)
Name of facility	Name of facility
Address	Address
City, State, Zip	City, State, Zip
Phone number Fax number	Phone number Fax number
Or from the following Gateway Family Health Clinic (please circle one)	Or to the following Gateway Family Health Clinic (please circle one)
4570 County Hwy 61 Moose Lake, MN 55767 P: 218-485-4491 F: 218-485-4724	204 Lundorff Drive Sandstone, MN 55072 P: 320-245-2250 F: 320-245-2555
P.O. Box 309 Hinckley, MN 55037 P: 320-384-6618 F: 320-384-6635	

_____ I give permission for the above facilities to share notes and other information regarding continuing care for a period of one year starting on the date of signature below.

INFORMATION TO BE RELEASED (Between dates of)_____ to _____

GFHC originated records (including lab, x-ray, etc) one year back are released according to policy with this authorization. If you are requesting additional year's history, we reserve the right to charge the current rate of $1.34 per page, and a retrieval charge of $17.79 per request for time spent copying records, according to MN State Statute 144.292 (Subd.6). **If you had care rendered at another facility please contact that facility for a copy of their original records.

IMPORTANT TO NOTE:*****All information regarding chemical dependency, mental health, alcohol/drug abuse and HIV/STD testing **will be** released unless patient **specifically denies consent** by initialing below.

_____ Chemical Dependency _____ Mental Health _____ Alcohol/Drug Abuse _____ HIV/STD

PLEASE RELEASE THE FOLLOWING INFORMATION (Check all that apply)

___ Any and all medical records
___ Physician notes
___ X-ray reports
___ X-ray films
___ Cardiac testing
___ Laboratory reports
___ Bills and/or statements
___ Other (please specify)_____

PURPOSE OF DISCLOSURE (Check all that apply)

___ Continuing care
___ Litigation
___ Insurance
___ Other (please specify)_____

I understand that if the person or entity that receives the information is not covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I do not authorize further release to any third party and hereby release the clinic, their employees and my physician(s) from any and all liability arising directly or indirectly from such redisclosure. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. A photocopy of this release will be considered valid as original. I understand that I may revoke this authorization in writing by contacting the Medical Records Department listed at the GFHC clinic address above. Unless otherwise revoked, this authorization expires in one year.

Patient/Guardian/P.O.A signature_____ Date_____
Relationship of authorized representative to patient_____
Witnessed by_____ Date_____
ID of requestor verified_____ yes _____ no Method_____ Who verified_____

Records release date_____ By_____ **Effective 02.2016**