WinnMed

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:

❒ WinnMed
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

_____ H_____ W_____
Birth Date Social Security # Telephone #s

Address: _____
Street City State Zip

This information is to be disclosed to:

❒ _____
Facility/Person
_____
Address

❒ WinnMed
901 Montgomery Street
Decorah, IA 52101

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

From (date) _____ to (date) _____

From (date) _____ to (date) _____

❒ I authorize the disclosure of information created within one year after the date the authorization is signed or prior to the te expiration date of the authorization.

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

_____

_____

The following information may be released:

❒ Medical Summary
❒ Discharge Summary
❒ Operative Report Examination
❒ History & Physical
❒ Emergency Room Report
❒ Consultation Reports
❒ Laboratory Tests
❒ Pathology Reports
❒ Photographs, videotapes, digital or other images
❒ Rehabilitation Documentation
❒ X-ray Reports
❒ Progress Notes
❒ Clinic Notes
❒ Billing Records
❒ Other: _____

Format: (Choose one, if no option is selected a paper copy will be given)
❒ Electronic ($5.00) ❒ Paper

_____
Signature of Patient/Guardian/Legal Representative Date Signed

Authorization to Release Patient Information

MR#: _____

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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
- ❒ Genetic testing

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 WinnMed, 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 WinnMed 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#:_____

Est. 12/05; Rev. 3/07, 6/08, 3/09, 3/12, 3/14, 12/16, 1/17, 5/23