Patient Name: LAST FIRST MI

Date of Birth

Medical Record Number

I hereby authorize:
(Name and address of releasing facility)

SMDC DULUTH CLINIC
400 E 3RD STREET
DULUTH, MN 55805

To Release Information to:
(Individual name, facility/organization and address)

EXAMONE/APS
800 NW CHIPMAN RD, SUITE 5900
P.O. BOX 2340
LEES SUMMIT, MO 64063-1149

PURPOSE OF DISCLOSURE:
( ) Continuing Care
( ) Payment of Claim
( ) School
( ) Worker's Compensation
( ) Legal
( ) For Personal Use
( ) Other (specify): _____

I specifically authorize the release of information relating to:
( ) Substance abuse (including alcohol/drug use)
( ) Behavioral Health
( ) HIV related information (AIDS related testing)

Signature of Patient or Personal Representative Date

INFORMATION TO BE RELEASED:

	Between Dates of:		Between Dates of:
( ) Discharge Summary		( ) X-Ray Reports	
( ) H&P Exam/Initial Evaluation		( ) X-Ray Films/MRI	
( ) Consult		( ) Diagnostic Test Reports	
( ) Counselor/Therapist Summary		( ) Procedure Reports	
( ) Progress Notes/Provider Notes		( ) Lab Reports/Pathology	
( ) Orders		( ) Correspondence	

( ) Other (specify content and dates): _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is 1 year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statue 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

Signature of patient, parent of minor, or personal representative Relationship Date

SMDC
St. Mary's/Duluth Clinic Health System

AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

White – Organization

Yellow – Patient

AUTH.001