Rainy Lake Medical Center
1400 Highway 71, Int'l Falls, MN 56649
P: 218-283-5463 F: 218-283-1034
ReleaseofInformation@rainylakemedical.com

RELEASE OF INFORMATION AUTHORIZATION

Rainy Lake MEDICAL CENTER

Patient Information (Please Print)

Last Name:	**First Name:**		**MI:**
Previous Name(s):			**Date of Birth:**
Street Address:	**City:**	**State:**	**Zip:**
Phone:	**Email (Optional):**		**Medical Record # (Optional):**

1. **Please release my records FROM:** *(Who has your records?)*
   - ☐ Rainy Lake Medical Center, 1400 Highway 71, International Falls, MN 56649
   - ☐ Clinic/Facility Name _____

   Address: _____
   City: _____ State: _____ Zip: _____
   Fax: _____ Phone: _____

2. **Please release my records to:** *(Who needs your records?)*
   - ☐ Rainy Lake Medical Center, 1400 Highway 71, International Falls, MN 56649
   - ☐ Clinic/Facility Name/Self/Other _____

   Address: _____
   City: _____ State: _____ Zip: _____
   Fax: _____ Phone: _____

3. **Date(s) of Service: ___/____/____/ through____/____/____** *(REQUIRED)*

4. **Information to be released:** *(Check appropriate box below)*
   - ☐ Billing Records ☐ Imaging Reports ☐ Lab Reports/Pathology ☐ Therapy Notes (PT/OT/ST)
   - ☐ Emergency Room Record ☐ Images on CD ☐ Operative/Procedure Reports
   - ☐ H&P/Discharge Summary ☐ Immunizations ☐ Progress/Clinic Notes
   - ☐ Other (*specify content – "ALL" will not be accepted*): _____

5. **Please initial to authorize the release of all information related to the records below:**
   Psychotherapy Notes Information_____(initial) Alcohol and/or Drug Use Information_____ (initial)
   Mental Health _____(initial) HIV/AIDS _____(initial)

6. **Date records are needed by:**____/_____/_____. *(Legal proof of identification is required for all requests.)*

7. **Purpose:** ☐ Personal ☐ Legal ☐ School ☐ Payment of Claim ☐ Continuing Care ☐ Workers Compensation
   ☐ Other (Please specify): _____

8. **Disclosure Format:** (*If electronic, please indicate preference:)*
   - ☐ Hardcopy/Paper ☐ US Mail ☐ Electronic ☐ Review of Record
   - ☐ Fax ☐ Verbal ☐ CD ☐ Other _____

   Email: _____

9. **By signing this form, I understand the following:**
   - ***This consent will end <u>one year</u> from the date the form is signed unless an earlier date or event is indicated:***
     EVENT: _____ **EXPIRATION DATE:** _____/_____/_____
   - I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to RLMC at the address above. Revocation will not apply to information that has already been disclosed in response to this authorization.
   - Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
   - Any disclosure of information carries with it the potential for unauthorized redisclosure by the recipient, and the information may not be protected by federal or state privacy regulations.
   - Requests for copies of medical records may be subject to retrieval and photocopying fees in accordance with MN statute 144.335.

_____ _____ _____

Patient Signature: (*If signing for a minor patient, I here by state my parental rights have not been revoked by a court of law).* Date Relationship to Patient

_____ _____ _____

Authorized Representative Signature: *An adult patient (18 years or older) authorize the release of their own medical record. If unable to authorize, legal documentation or proof of right of access must be provided.* Date Relationship to Patient *(if applicable)*