RIVERWOOD HEALTHCARE CENTER
200 Bunker Hill Drive, Aitkin, MN 56431
218-927-2121

AUTHORIZATION FOR THE USE OR DISCLOSURE/RELEASE OF PROTECTED INFORMATION

Patient name: ____ Other names: ____________________________________
DOB: ____________________ Social Security #: _______________________ RHCC MR# _______________

The undersigned hereby authorizes Riverwood Healthcare Center to:

_____ disclose to ____
Hospital, doctor, insurance or attorney

_____ obtain from ____
Address

____
City/State/Zip

the following confidential, oral and written information from the records of the patient identified above from:
_____ Hospital _____ Aitkin Clinic _____ McGregor Clinic _____ Garrison Clinic

_____ History & Physical _____ Laboratory Reports _____ Consultation Reports
_____ Discharge Summary _____ Complete Medical Record _____ X-ray Films
_____ Operative Reports _____ Provider Progress Notes _____ X-ray Reports
_____ Pathology Reports _____ Emergency Room Record _____ Bills and/or Statements
_____ Other ____________________________

for the following medical condition or injury: ____
occurring on or about (dates of treatment):____

for the purpose(s) of:
_____ Continuing Care _____ Insurance Claim(s) _____ Litigation _____ Other (Explain) ___________________________________

Any and all medical records including records relating to communicable diseases such as HIV, AIDS and sexually transmitted diseases will be released unless otherwise indicated by placing patient/legal representative's initials here: ____. Any and all medical records including records relating to mental health records or chemical dependency records will be released unless otherwise indicated by placing patient/legal representative's initials here:____.

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 re-disclosed and no longer protected by these regulations. I do not authorize further release to any third party and hereby release the hospital, clinic, their employees and my physician(s) from any and all liability arising directly or indirectly from such re-disclosure. A copy or fax of this authorization shall be as valid and may be used and relied upon with the same force and effect as the signed original thereof.

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 and/or request copies of any information used/disclosed under this authorization.

I understand that I may revoke this authorization by mailing or presenting the written request in person to Riverwood Healthcare Medical Records Department, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization expires once the above stated purpose is fulfilled or one year, whichever comes first.

____ ______________ ____
Signature of patient or legal representative Date Signature of witness

____ ____
Relationship to patient, if other Reason patient unable to sign

Date records needed _____________________ Records faxed to _________________________ Date records faxed___________

_____ Patient/other picked up records Date picked up, by whom & how verified ____

_____ Records not sent due to ____ Records sent (date) ____________
Released by___________________