Riverwood Healthcare Center
200 Bunker Hill Dr.
Aitkin, MN 56431
Phone: (218) 927-2121
Fax: (218) 927-5319

Medical Record Release Authorization

Patient Name______________________________Maiden Name_______________SS#__________

Date of Birth_______________Home Phone____________________Cell/Work___________________

Address____City/State/Zip________________________

Email Address: ____

A) I hereby authorize records FROM:

Name____

Address____

City/State/Zip___________________________________

Phone#__________________Fax#___________________

B) To be released TO:

Name____

Address____

City/State/Zip____

Phone#______________________FAX#________________________________

C) For the purpose of:

_____ Litigation
_____ Disability
_____ Insurance
_____ Work Comp
_____ Self/Personal Copy
_____ Other
_____ Transfer or Continuity of Care

Date Range______________________to____________________

- ☐ Physician Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Immunizations
- ☐ Lab/Path Reports
- ☐ Operative/Procedure Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other _______________
- ☐ Digital Images

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires once the above stated purpose is fulfilled or one year, whichever comes first.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

___________ ____
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

Signature of Witness____________________________________

All incomplete forms will be returned for completion prior to processing the request.