

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 _____
_____ obtain from _____
Hospital, doctor, insurance or attorney
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) _____