Meeker Memorial Hospital & Clinics
Authorization for Release of Health Information

Please see directions for additional information on completing.
Please Print

Patient Information	Name		Date of Birth
	Address		Phone Number
	City	State	Zip
	Previous Name		
Release Information From	Specific Provider		
	Address		Phone Number
	City	State	Zip
Release Information To	Name of person, business, specific clinic / hospital, or health care provider		
	Address		Phone Number
	City	State	Zip

Information to be released
Only the information check marked will be released

Date(s) of service: from _____ **to** _____
Note: If dates are not specified, only the most recent visit/encounter will be released.

- ○ History and physical
- ○ Emergency Room notes
- ○ Progress notes
- ○ Other (specify):
- ○ Pathology reports
- ○ Consult reports
- ○ Laboratory reports
- ○ Operative/Procedure notes
- ○ Radiology reports Discharge Summary
- ○ *Radiology films
- ○ All records (*not included) Assessment / Evaluation

Special Disclosure

○ Substance use or disorder Dates of service: from _____ to _____
Concerning: _____ (Specific diagnosis or treatment – do not list ICD-10 codes)
Per Federal Rule 42 CFR Part 2, this section must be completed to release substance use disorder records.

Preferred Method

○ MyChart (If you do not have MyChart access, please visit www.meekermemorial.org)
○ Paper

Reason for release

○ Continuation or Transfer of Care (to another provider) ○ Personal Use
○ Attorney ○ Insurance ○ Other (specify): _____

Authorization	Patient /Guardian signature	Date
	Relationship to patient	Reason patient is unable to sign

Revocation

This authorization will expire one year from the date of signature unless I indicate a different date or event here: _____. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it or upon final disposition of the conditional release for which authorization was given. I may revoke this authorization at any time by notifying, in writing, the provider / facilities listed in the FROM section. I understand that such revocation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

Meeker Memorial Hospital & Clinics (MMHC) will not refuse treatment to any patient that refuses to sign an authorization for release of Protected Health Information. Once released, the information will no longer be covered under the Federal Privacy Laws. Information not originated by Meeker Memorial Hospital & Clinics cannot be released to another facility. I understand that my medical record is part of the Meeker Memorial Hospital & Clinics' Electronic Medical Record. Meeker Memorial Hospital & Clinics share an electronic medical record. Authorizing the release of the following items: Medication List, Allergy List, Problem List, Immunization Data and/or Medical History includes the release of this information from all MMHC sites that share an electronic medical record.

MEEKER MEMORIAL
HOSPITAL & CLINICS
Care as it should be.

Revised 10/20

Directions for Completion of Meeker Memorial Hospital & Clinics Authorization for Release of Health Information

Patient Information: Complete the entire section which identifies clearly the demographic information specific to the patient (individual who information is being requested for).

Release Information From: Identify which Meeker Memorial hospital, clinic, or provider you are seeking information from. Please be specific in your request.

Release Information To: Identify the full name of individual, business, hospital, clinic, or provider you want to receive your records. Be sure to include their address and phone number.

Information to Be Released: This section gives us the instructions for what information you want released. It is very helpful to identify the date or range of dates needed. If you do not have dates noted, only your last hospital encounter or clinic visit at the specific Meeker Memorial Hospital & Clinics location you indicated will be released. Only the specific information checked will be released.

Special Disclosure: This section is required per Federal Rule 42 CFR Part 2 to be completed in full to allow Meeker Memorial Hospital & Clinics to release Substance Use Disorder records. Even if you have indicated dates in the Information to be Released section, the dates of Substance Use Disorder records to be released is required in this section.

Preferred Method: This tells us how you would like your information provided. We can print the records or release them to your MyChart portal. Note: If your original records are on paper, we are only able to provide them on paper.

Reason for Release: Please identify the reason you need a copy of your record. This helps us track and assign a priority status to your request. It also informs us determine who may be responsible for the cost of records (where applicable).

Revocation: This authorization will automatically expire 1 year after your signature unless you indicate another date or event upon which the authorization should expire OR you provide a written revocation to our organization.

Please send your completed authorization to: Attn: Release of Information; Health Information Services at Meeker Memorial Hospital & Clinics at 612 S Sibley Ave, Litchfield, MN 55355.