Glencoe
REGIONAL HEALTH

AUTHORIZATION TO TRANSFER MEDICAL INFORMATION

FROM OTHER FACILITY:

_____
Name

_____
Address City State Zip

For the purpose of continuing medical care, I hereby authorize and request you to furnish the following information to:

GLENCOE REGIONAL HEALTH
1805 Hennepin Avenue North
Glencoe, MN 55336-1416
Phone: 320-864-7993 Fax: 320-864-7998

Patient Name _____Date of Birth _____MR# _____

Email _____ Telephone _____ Physician _____

Address_____

_____ Office Notes from: _____to_____

_____ Laboratory Reports from: _____to_____

_____ Radiology Reports from: _____to_____

_____ Radiology Films from: _____to_____

I understand the following information will not be released to Glencoe Regional Health without my signature. Therefore, I specifically authorize the release of information relating to:

- ❑ HIV-Related Information (Including AIDS Related Testing)
- ❑ Substance Abuse (alcohol/drug abuse)
- ❑ Mental Health (includes psychological testing)

_____ _____
Signature of Patient/Guardian/Legal Representative Date

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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 will expire one year from the date of my signature.

I understand that authorizing the disclosure of the health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

_____ _____ _____
Signature of Patient/Guardian/Legal Representative Relationship to Patient Date