Family Practice Medical Center
502 SW 2nd St, Suite 1 Willmar, MN 56201
Phone: 320-235-7232
Fax: 320-231-8602

Authorization for Release of Information

I hereby authorize _____

to release to (facility name, address, telephone number and fax number):

_____

_____

_____ _____ _____
Patient Name DOB SSN

Please process records by: ___/___/___ *** All completed requests will be processed within 2 weeks

Please send records via: Mail Fax to: (____)_____ Patient will pick up

Information to be released:

_____ Discharge Summary
_____ History and Physical
_____ ICC form
_____ Progress Notes
_____ Immunization Records
_____ Operative Report
_____ All records (last 5 years) (including mental health records, HIV, STD and pregnancy testing)
_____ Lab reports
_____ X-ray _____
_____ Other _____

Reason for needing records:

_____

_____

This authorization shall remain in effect from the date signed below until _____(expiration date or event). If no date of expiration or event is specified, the authorization will expire in six months.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting FPMC at the address above
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA
- I may refuse to sign the authorization and that FPMC will not condition treatment or payment on my providing this authorization

_____ _____
Signature of Patient or Authorized Legal Representative Date

_____
Relationship to Patient

Internal Use Only Records Copied: ____/____/____ Records copied by: _____