

Semcac Family Planning Clinic

Authorization Form for Release of Information

Patient Name: _____ Patient #: _____
LAST FIRST MI MAIDEN/OTHER NAME

Birthdate: _____ Day Phone: _____ Evening Phone: _____
MO/DAY/YEAR

I HEREBY AUTHORIZE TO RELEASE MY HEALTH INFORMATION

FROM:

Name: _____ Semcac Family Planning Clinic _____
(Person or Clinic)

Address: _____ 76 West 3rd Street _____

City: _____ Winona _____ State: _____ MN Zip: _____ 55987 _____

Phone: _____ 507-452-4307 _____ Fax: _____ 507-457-0564 _____

TO:

Name: _____ + _____
(Person or Clinic)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Health Information to be Released

I specifically authorize release of the following information:

Entire Medical Record *OR* (check appropriate boxes)

Medical History

Record of **Well Woman Exam**

Lab Results (non-HIV, **including Pap results**)

Colposcopy Records

Progress Notes

Other: _____

Dates:

Reason for Release of Information: **Continuation of Care** _____ Other: _____

Conditions of Authorization

1. This Authorization will expire on: _____

2. I may revoke this Authorization at any time by notifying Semcac in writing, and it will be effective on the date notified except to the extent that Semcac has already acted upon such Authorization.

3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected Federal privacy regulations.

4. Semcac will not penalize me if I do not sign this authorization.

5. I have been offered a copy of this signed Authorization form.

X

Patient Signature Date
(or legally appointed representative)

Employee Signature Date

PT. IDENTITY CONFIRMED BY (picture I.D./Signature/SS#): _____