Authorization Form for Release of Information

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

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

I HEREBY AUTHORIZE TO RELEASE MY HEALTH INFORMATION

FROM:	**TO:**
Name: _____Semcac Family Planning Clinic____ (Person or Clinic)	Name: _____+_ _____ (Person or Clinic)
Address: _____420 E. Sarnia Street, Suite 1600____	Address: _____
City: __Winona_____ State: _MN Zip: __55987_	City: _____ State: _____ Zip: _____
Phone: _507-452-4307___ Fax: _507-457-0564____	Phone: _____ Fax: _____

Health Information to be Released

I specifically authorize release of the following information:

Dates:

- ❑ 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: _____ _____

- ❑ **Reason for Release** of Information: __x__ **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#): _____