INTEGRACARE CLINIC Foley
471 MN-23, Foley, MN 56329
(320) 968-7234

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

AUTHORIZES:

WILLIAMS/INTEGRACARE CLINIC
100 SOUTH 2ND STREET, PO BOX 296
SARTELL, MN 56377

DBA:
INTEGRACARE/WILLIAMS CLINIC
INTEGRACARE LTD.
WILLIAMS CHIROPRACTIC CLINIC
URGENT CARE

_____ RELEASE PROTECTED HEALTH INFO TO:

_____ DISCLOSURE PROTECTED HEALTH INFO TO:

_____
NAME OF PROVIDER/PLAN/OTHER

_____
STREET ADDRESS

_____
CITY,STATE,ZIP CODE

INFORMATION TO BE RELEASED/DISCLOSED: (CHECK APPLICABLE CATEGORIES)
(I UNDERSTAND THAT ONLY PROTECTED HEALTH INFORMATION GENERATED BY YOUR CLINIC CAN BE RELEASED OR DISCLOSED)

___ MEDICAL HISTORY, EXAM, REPORTS
___ TREATMENT OR TESTS
___ IMMUNIZATIONS
___ X-RAY REPORTS
___ LABORATORY REPORTS
___ CONSULTATIONS
___ SURGICAL REPORTS
___ HOSPITAL RECORDS INCLUDING REPORTS
___ ALLERGY RECORDS
___ PRESCRIPTIONS
___ ENTIRE RECORD
___ OTHER (SPECIFY):_____

IN COMPLIANCE WITH MINNESOTA STATUTES, WHICH REQUIRE SPECIAL PERMISSION TO RELEASE OTHERWISE PRIVILEGED INFORMATION, PLEASE RELEASE RECORDS PERTAINING TO:

___ MENTAL HEALTH
___ ALCOHOLISM
___ HIV (AIDS)
___ DEVELOPMENTAL DISABILITIES
___ DRUG ABUSE
___ SEXUALLY TRANSMITTED DISEASES
___ OTHER (SPECIFY) _____

FOR THE FOLLOWING DATE(S): _____

PURPOSE FOR NEED OF DISCLOSURE (CHECK APPLICABLE CATEGORIES)

___ FURTHER MEDICAL CARE ___ PERSONAL

___ INSURANCE ELGIBILITY/BENEFITS ___ CHANGING PHYSICIANS

___ LEGAL INVESTIGATION OR ACTON ___ OTHER (SPECIFY): _____

I understand that if the person(s) and/or organizations listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your Right with Respect to This Authorization

- **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. As a provider or Health Plan, the rule permits you to condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on the singing of this authorization in the following circumstances:
    - (a) A health care provider may condition the provision of research-related treatment on the provision of an authorization to use and/or disclose an individual's health information for such research.
    - (b) A health plan may condition enrollment in the health plan or eligibility for benefits on the provision of an authorization required prior to enrollment in a health plan, if:
        - (i) the authorization is for the health plan's eligibility or enrollment determinations or for its underwriting or risk rating determination and
        - (ii) the authorization if not for the use and/or disclosure of psychotherapy notes:
    - (c) an entity subject to the Rule may condition the provision of health care that is solely for the purpose of creating health information for disclosure to a third party on the provision of an authorization for the disclosure of the health information to such third party.

  If you wish to make such conditions, you must include a description of these circumstances upon signing of this authorization.
- **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Medical Records Supervisior. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization is good for 1 year from the date signed below.

_____ _____

Patient Signature Date

(If signed by a person other than the patient, state relationship and authority to do so.)

Patient is: ____ Minor ____ Incompetent ____ Disabled ____ Deceased

Legal Authority: ____ Custodial Parent ____ Legal Guardian ____ Executor of Estate of Deceased

____ Power of Attorney for Healthcare ____ Authorized Legal Representative