Southern Metro Medical Clinics

Belle Plaine • Le Sueur • Montgomery • New Prague

Belle Plaine Clinic	Le Sueur Clinic	Montgomery Clinic	New Prague Clinic
700 West Prairie Street	500 N. Main, Ste. 101	501 4th Street NW	301 E. Main Street
Belle Plaine, MN 56011	Le Sueur, MN 56058	Montgomery, MN 56069	New Prague, MN 56071
Direct: (952) 873-2276	Direct: (507) 665-4017	Direct: (507) 364-5600	Direct: (952) 758-4461
Fax: (952) 873-4222	Fax: (507) 665-4019	Fax: (507) 364-5686	Fax: (952) 758-5011

AUTHORIZATION TO DISCLOSE AND PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT INFORMATION
Patient Name (Last, First)
Street Address
City-State-Zip Code
Phone Number
DOB

INFORMATION OBTAINED FROM	INFORMATION RELEASED TO
Name - Street Address - City - State - Zip Code - Phone # - Fax #	Name - Street Address - City - State - Zip Code - Phone # - Fax #

PLEASE CHECK THE INFORMATION TO BE DISCLOSED

- ☐ History & Physical, most recent
- ☐ EKG
- ☐ Immunization Record
- ☐ Lab Results
- ☐ Pathology Reports
- ☐ X-ray typed reports
- ☐ X-ray films
- ☐ Billing Statements
- ☐ Other: ____________________
- ☐ Medical records regarding treatment for: ____________________ Occurring on or about: __________ (date)

PURPOSE OF DISCLOSURE

- ☐ Consults/Second Opinion
- ☐ Continuing Care
- ☐ Education/Research
- ☐ Insurance Processing
- ☐ Litigation - Attorney
- ☐ Patient Access/Personal
- ☐ Relocating
- ☐ Other: __________

DISCLOSURE RESTRICTIONS

NOTE: All records pertaining to sexually transmitted disease, AIDS-related illness, behavioral or mental health, and/or alcohol and drug abuse will be disclosed unless otherwise indicated here.

1. I may cancel this authorization at any time. Canceling this authorization does not apply to the information that has already been given out. If not otherwise cancelled, this authorization will be in effect for one (1) year.
2. I have the right to see or copy the health information to be given out as provided in CFR 164.524.
3. I do not have to sign this form. If I do not sign, Southern Metro Medical Clinics staff cannot give out the information that I have asked to be disclosed above. I need not sign this form in order to assure treatment.
4. An electronic or photocopy version of this form is as valid as the original.
5. A fee may be charged in accordance with MN statue 144.335 and Federal Rule 164-524.
6. Federal privacy laws may not protect information that is disclosed to other persons or entities.

Patient Signature or Patient Representative Signature

X **Date:**

Patient is: Minor Incompetent Disabled Deceased ~Relationship to Patient: __________

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For Office Use Only: Mailed Faxed Picked up by: ____________________

Information Disclosed By: Name/Title: ____________________ Date: ____/____/____