Ortonville Area Health Services
Ortonville Hospital 320.839.2502
Northside Medical Clinic 320.839.6157
Northridge Residence 320.839.6113
OAHS Home Health 320.839.4020
Clinton Clinic 320.325.5217
Fairway View 320.839.2397
www.oahs.us

Consent Form to Release Health Information

Patient Information:

*First Name: _____ *Middle Name: _____ *Last Name: _____

Previous Name(s): _____ *Date of Birth: _____ Phone: _____

Address: _____

I am asking for health information to be ***released from***:

*Facility/Provider/Individual: _____

*Address: _____ Phone: _____

_____ Fax: _____

I am asking for health information to be ***released to***:

*Facility/Provider/Individual: _____

*Address: _____ Phone: _____

_____ Fax: _____

Information to be released:

Important: indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☐ All health information

Or to only release specific portions of your health information, indicate the categories

☐ History/Physical	☐ Mental health	☐ HIV/AIDS testing
☐ Laboratory report(s)	☐ Discharge summary	☐ Radiology report(s)
☐ Emergency room report(s)	☐ Progress note(s)	☐ Radiology image(s)
☐ Surgical report(s)	☐ Care plan	☐ Photograph(s), video, images
☐ Medications	☐ Immunizations	☐ Billing records

☐ Instructions or other information: _____

*Reason(s) for releasing information:

☐ Patient's request ☐ Treatment/continued care ☐ Exchange of information ☐ Payment ☐ Legal ☐ Insurance application

☐ Other (provide information/instructions): _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in twelve months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment, payment, enrollment or eligibility for benefits. I understand that when the health information is disclosed to the above individual or organization that the information could be re-disclosed and may no longer be protected by federal or state privacy laws. There may be a charge to obtain copies of medical records.

_____ _____ _____

*Signature of Patient or Legal Representative | Relationship if signed by representative | *Date

_____

Signature of Witness Date

Symbol/and highlighted text means that the section or field is required to be filled in, if not completed in full the release will not be honored and will be returned

Fax number for Ortonville Area Health Services release of information is (320) 839-3851, Address 450 Eastvold Ave, Ortonville MN, 56278

Office Use Only: Records were already released Mode (fax, mail, or patient picked up: _____ Initials: _____ Date: _____
I helped the patient complete the form Initials: _____