welia HEALTH

CONTACT INFORMATION
Health Information Services/Release of Information
301 Highway 65 South, Mora, MN 55051
Phone: 320-225-3501 / Fax: 320-225-3507
WeliaHealth.org

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information
Complete the entire section which identifies clearly and legibly the entire demographic information specific to the patient.

Patient Name: _____ Date of Birth: _____

Address: _____ Day Phone: _____

City: _____ State: _____ Zip: _____

Clinic/Hospital/Health Care Provider
(Who has the information you want released?) Please list the specific hospital or clinic.

Fax: _____

Name: _____

Address: _____ Day Phone: _____

City: _____ State: _____ Zip: _____

Receiving Party
(Where do you want the information sent?) Identify the full name/business, address, phone and specific contact information of who is to receive the information. Please allow 7-10 days for request to be processed and sent to the recipient.

Name: _____ Attention: _____

Address: _____ Day Phone: _____

City: _____ State: _____ Zip: _____

Fax Number (Urgent Patient Care Only): _____

Information to be Released
This section gives us the instructions for what information you want released. If you select "Routine Record Set" for hospital or clinic, we will disclose information that is specific to that care visit. This is typically what the health care provider wanting information will need.
It is very helpful if you identify the date or range of dates that are needed.

This consent will automatically expire in 12 months *unless* you write another date. The authorization is revoked at your written direction to our organization.

Routine Record Sets: Date(s) of Service: _____
- ❒ Clinic (office visit, lab, radiology, medicines, immunizations)
- ❒ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)
- ❒ Billing Records
- ❒ Copies of Films/Images
- ❒ Any and all records (includes ALL types of records listed below. If you want to include images and billing records check those boxes.)

Only record types checked below will be released.

- ❒ Discharge summary/note
- ❒ Radiology reports
- ❒ Emergency record(s)
- ❒ Medication records
- ❒ History & Physical exam
- ❒ Rehab records (PT/OT/ST)
- ❒ Immunization/allergy records
- ❒ Operative report
- ❒ Laboratory reports
- ❒ Pathology reports
- ❒ Consultations
- ❒ Progress notes/clinic notes
- ❒ Mental health records
- ❒ Other records specify record type(s)
- ❒ _____
- ❒ _____

Optional Limits — Disclose only records related to following:
Date(s) of service/: _____ injury or illness: _____

Release Instructions
(**How** and **When** do you want the information?) This will tell us how you would like the information delivered. We can print the document or create a CD. If you wish to view your information prior to being printed, please contact us to set up an appointment. Please note that viewing of records is only done during normal office hours.

Date Information is needed: _____
Note: (24 hour notice is required.)

Release Method:
❒ Paper ❒ CD ❒ View my record ❒ Fax (patient care only)

Purpose of Release
Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request.

- ❒ Continuing Care
- ❒ *Personal use/review
- ❒ School/Day Care
- ❒ *Insurance
- ❒ *Social Security
- ❒ *Other: _____
- ❒ Transfer of Care
- ❒ *Litigation/Legal

*Fees may be charged in accordance with MN State 144.292 and Federal Rule 45 C.F.R. 164.524

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Welia Health's Notice of Privacy describes how to cancel (revoke) this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Welia Health records may include records that it received from other organizations. If these records have been used by Welia Health and filed in the record Welia Health maintains about you, these records may be released with your Welia Health records.
- Welia Health cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Welia Health from any and all liability resulting from a re-disclosure by recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.
- I understand that Welia Health will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

_____ _____
Patient/Legal Guardian Signature Date

00200

❒ **COMPLETED** ❒ **TO BE DONE**

WH Auth Release 09/2019

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