505 12th Ave. W., Ste. 1, Virginia, MN 55792
(218) 749-2877 Fax: (218) 749-6033

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient Name Date of Birth

TO: ☐ Release ☐ Obtain ☐ Exchange Information with:

AUTHORIZATION
I hereby authorize:
Arrowhead Center, Inc.
505 12th Ave W
Virginia, MN 55792

_____
_____

PURPOSE OF DISCLOSURE

- ☐ Continuing Care
- ☐ School
- ☐ Worker's Compensation
- ☐ Other (Specify content and dates): _____
- ☐ Personal Use
- ☐ Legal Matter

INFORMATION TO BE RELEASED: Between the Dates of: _____ to/ and/ present _____

- ☐ All Medical Records including imaging reports but NOT imaging films
- ☐ Psychiatric/Psychological/Neuropsychological Testing
- ☐ Completed Form
- ☐ Written Communication
- ☐ Oral Communication
- ☐ Progress Notes/Provider Notes
- ☐ Discharge Summary
- ☐ Other (Specify): _____
- ☐ CD Counselor/Therapist Reports
- ☐ Transfer/Outside Information
- ☐ Diagnostic Test Reports
- ☐ H&P Exam/Initial Evaluation
- ☐ Correspondence
- ☐ Procedure Reports
- ☐ Lab Reports/Pathology

ACKNOWLEDGEMENT OF UNDERSTANDING:

I understand the expiration date of this authorization is _____or 1 year from today's date, whichever is sooner.
I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
I understand that Arrowhead Center, Inc. may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
I understand I will receive a copy of this form upon request.
I understand that in compliance with MN STATUE 144.335 I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
I understand a photocopy or fax of this form is the same as the original.

_____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date

Disclosure of this material is prohibited by law: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.