Lakeview Clinic

Release of Protected Health Information

*ONE PATIENT PER FORM

1. Patient Information: *This information is used to identify your health information and ensure only your information is sent.*

Patient Legal Name: _____ Birth date: _____

Mailing address: _____

Previous Name(s): _____

Phone numbers (Mobile): _____-_____-_____ (Home): _____-_____-_____ (Other): _____-_____-_____

2. I am requesting health information be released **from** at least one of the following (check **one** option):

- ☐ Lakeview Clinic, Ltd.
- ☐ Hospital/Clinic/Provider:
  (name): _____
  (location) _____
  (fax number) _____
- ☐ Hospital/Clinic/Provider:
  (name) _____
  (location) _____
  (fax number) _____

3. I am requesting health information be **sent** to:

- ☐ Lakeview Clinic, Ltd.
  Attention: _____
  424 State Hwy 5 West
  Waconia, MN 55387 **Fax: (952)442-2970**
- ☐ Organization or Individual Name_____
  Attention:_____
  Fax Number: _____
  Address: _____
  City: _____ State: ___ Zip.:____

4. Information to be released: *IMPORTANT: Indicate only the information you authorize to be released.*

Specific dates/years of treatment: _____

☐ Release ALL health information (This includes information related mental health evaluations & treatment, concerns about drug &/or alcohol abuse, HIV/AIDS testing & treatment, sexually transmitted diseases, and genetic information.)

OR

☐ Release only specific portions of your health information. Use the categories below to indicate specified information.

☐ History/Physical	☐ Surgical Report	☐ Care Plan	☐ Radiology Report
☐ Laboratory Report	☐ Emergency Room Report	☐ Mental Health	☐ Radiology Images
☐ Immunizations	☐ Discharge Summary	☐ HIV/AIDS testing	☐ Photographs/digital/images
☐ Medications	☐ Progress Notes	☐ Billing Records	

☐ Other: (specify)_____

5. The following information requires special consent by law.

Even if you indicate a release of ALL health information, you must specifically request the following information be released. (check boxes)

☐ Chemical dependency program:_____ ☐ Psychotherapy notes: _____

☐ Confidential services provided to minors relating to: Pregnancy, Contraceptive Counseling, STI Testing, & Substance Use require the minor patient to sign for release of this information.

6. Reason(s) for releasing information: *(Check all that apply.)*

☐ Patient request	☐ Treatment/continued care	☐ Insurance application	☐ Legal
☐ Review patient's current care	☐ Payment	☐ Appeal denial of Social Security Disability	

☐ Other (please explain): _____

Consent & Expiration:

- By signing this form, I request that the health information specified in section 4 & 5 be sent to the third party named in section 3.
- I may stop this consent at any time by writing to the organization(s) and or professionals named in section 3.
- If the organization or professional named in section 3 has already released health information based on my consent, my request to stop will not apply to the released information.
- I understand that the health information specified in section 4 & 5 is sent to the third party named in section 3; the information could be re-disclosed by the receiving third party and it may no longer be protected by federal or state privacy laws.
- I understand that if the organization named in section 3 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

Patient Signature _____ Date: _____

OR legally authorized representative's signature_____

Representative's relationship to the patient: _____ Date: _____

If the representative is not the parent of a child under 18, please attach proof of legal guardianship documents on file.

This consent expires one year after signing unless I specify an earlier date or event below.

Optional consent end date OR specified event that ends consent: _____

Questions? Call (952)442-4461 & request medical records dept.