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 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: _____

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.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event below.

End Date of Consent: _____ OR specified event: _____

Patient Signature _____ Date: _____

OR legally authorized representative's signature_____ Date: _____

Representative's relationship to the patient: _____

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

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