Mankato Clinic
1230 East Main Street
Mankato, MN 56002-8674
- **Main ROI:** Phone: 507.389.8633 Fax: 507.625.8980
- **Wick/CHC ROI:** Phone: 507.385.4037 Fax: 507.388.1878
- **North ROI:** Phone: 507.385.3959 Fax: 507.345.4130

Authorization to Release and Disclose Patient Information

MR#:

ROI@mankato-clinic.com

Patient	Name:		Date of Birth:
	Address:		Phone:
	City:	State:	Zip:
	Previous Name:		
Release my medical records from	WHO HAS INFORMATION YOU WOULD LIKE RELEASED? Name:_____ Location: _____ Address: _____ Fax #: _____ City: _____ State: _____ Zip: _____		
Share my medical records with	TO WHOM SHOULD THE INFORMATION BE RELEASED? Name:_____ Appt Date:_____ Address: _____ Fax #: _____ City: _____ State: _____ Zip: _____		
Information to be disclosed	MEDICAL RECORD RELEASE: Records concerning: _____ Specific Diagnosis or Treatment and Specific Dates of Service		
	☐ Past 2 years of records ☐ Immunizations ☐ HIV / AIDS records ☐ Clinic/Hospital notes ☐ Financial / Billing ☐ Mental health/substance abuse ☐ Radiology reports ☐ Last colonoscopy, mammogram, Pap, eye exam ☐ Radiology films / CD / other Communication (check one / both) ☐ Verbal ☐ Written ☐ Lab / Pathology Reports ☐ Other: _____		
Reason for the release	☐ Legal ☐ Continuation of Medical Care ☐ No records needed at this time; keep on file ☐ Insurance ☐ Other (specify): _____ ☐ Personal ☐ Transferring care (please indicate new provider):_____		
Revocation	I understand that this authorization will be in effect for 12 months from the date signed unless cancelled by me in writing and that my cancellation will take effect when the provider receives my notice in writing. A photocopy of this authorization will be treated in the same manner as original.		
Authorization	I understand that Mankato Clinic will not condition my treatment on whether I sign this authorization form, except in the following situations: (1) if treatment is related to research (such as a clinical trial), and the information will be disclosed as part of that research; or (2) if the purpose of the treatment is so that information can be disclosed to a third party (such as to an employer for a fitness-for-work examination). I understand that once information is released pursuant to this authorization, Mankato Clinic cannot prevent the re-disclosure of the information to another third party. I understand there may be a charge associated with the Release of Information services rendered. _____ _____ **Signature of patient/legal representative*** **Date** _____ **Printed name of legal representative and relationship to patient** (Parent, Guardian, Healthcare POA, etc.)		

** Authorized representative may be required to submit copies of legal documents supporting his/her authority to act on a patient's behalf*

COPIES: GIVEN / MAILED / FAXED ON: _____ / CALL WHEN READY / PICK UP: _____

MC032 (02/23)

FACILITIES: Please fax medical records to: 507.385.4180	PATIENTS: Please fax signed authorizations to: 507.388.1878

Mankato Clinic

AUTHORIZATION INSTRUCTIONS

In order to release your medical records, an authorization form must be completed. Any HIPAA compliant authorization form can be used. Please see directions below on how to complete this form.

PATIENT: Please legibly complete this entire section and include any previous legal names that you might have had.

RELEASE MY MEDICAL RECORDS FROM (health care facility/provider): List what facility/provider you are seeking information from. Please be as specific as possible so that we can correctly identify which facility has your medical records you would like released.

SHARE MY MEDICAL RECORDS WITH (requestor): Where would you like your records sent? Who would you like to have access to your records? Please legibly complete this entire section including as much information as possible. If you have an upcoming appointment, please be sure to include that in the space provided in this section. We prioritize requests by appointment date.

INFORMATION TO BE DISCLOSED: Please indicate what information you would like released. *NOTE: In Minnesota, immunizations do not require a signed authorization form to release.* If mental health or substance abuse records are requested, please mark appropriate box. If you would like another person to have either verbal or written access to your medical records, please check the appropriate Communication boxes.

REASON FOR THE RELEASE: For tracking purposes, please indicate why you are requesting records. If you are transferring care to another facility, please mark the Transfer Care box and write in the name of your new primary provider.

REVOCATION: This authorization form will be valid for one year from the date signed. Authorization can be revoked by the patient if requested as such in writing.

AUTHORIZATION: Authorization form needs to be signed by the patient or have legal authority to sign on behalf of the patient. Legal documentation of authority must be on file or will need to be submitted at time of request. Spouses or parents of children 18 and older are not able to sign for patient unless they are a legal representative of the patient and can provide appropriate documentation.

ADDITIONAL INFORMATION:

- Mankato Clinic does not re-release medical records from other facilities.
- Please expect at least 7-10 business days from receipt of your request for processing; exceptions are made for emergent circumstances.
- Please bring a photo ID with you in order to pick up medical records.
- Mankato Clinic does not accept typed signatures unless a verification program is utilized.