THE COLLEGE OF SAINT BENEDICT HEALTH SERVICES

37 S. College Ave Saint Joseph, MN 56374

Phone: 320-363-5605 Fax: 320-363-6396

Authorization for Disclosure of Protected Health Information

Patient Name:_____ **Date of Birth:**_____

I hereby authorize: ( ) Disclose to ( ) Obtain from ( ) Exchange with

The College of Saint Benedict
Health Services
37 S. College Ave
Saint Joseph, MN 56374

Name/Entity:_____
Address:_____
Phone/Fax:_____

PURPOSE OF DISCLOSURE:

( ) Continuation of Care

( ) Other (please specify): _____

INFORMATION TO BE DISCLOSED:

( ) Any and all medical records ( ) Radiology reports

( ) Laboratory/Pathology Reports ( ) Immunizations Records

( ) Verbal exchange only

( ) Records regarding treatment for _____

( ) Other _____

DATES OF INFORMATION TO BE RELEASED: From: _____ TO _____

I understand that this authorization will remain in effect one (1) year from the date of signature. I also understand that it may be revoked by me in writing at any time, but would not apply to any information already released in good faith. Any further disclosure of medical information by recipient(s) is not authorized without the specific written consent of the person to whom it pertains. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. A photocopy of this authorization will be treated in the same manner as an original.

_____ _____

Signature of Patient or Legal Representative Date