Rainy Lake Medical Center
1400 Highway 71, Int'l Falls, MN 56649
P: 218-283-5463 F: 218-283-1034

RELEASE OF INFORMATION AUTHORIZATION

Patient Information (Please Print)

Last Name:	First Name:		MI:
Previous Name(s):			Date of Birth:
Street Address:	City:	State:	Zip:
Phone:	Email (Optional):		Medical Record # (Optional):

1. Please release my records FROM: *(Who has your records?)*

☐ Rainy Lake Medical Center, 1400 Highway 71, International Falls, MN 56649

☐ Clinic or Facility Name ____

Address: ______________________________ City: ______________________________

State: ____________ Zip: __________ Fax: __________________ Phone: ________________

2. Please release my records to: *(Who needs your records?)*

☐ Rainy Lake Medical Center, 1400 Highway 71, International Falls, MN 56649

☐ Clinic or Facility Name ____

Address: ______________________________ City: ______________________________

State: ____________ Zip: __________ Fax: __________________ Phone: ________________

3. Date(s) of Service: ____/____/____/ through ____/____/____. *(If blank, we will release 1 years' worth of most recent records.)*

4. Information to be released: *(Check appropriate box below)*

☐ Emergency Room Record ☐ Nursing Notes ☐ H&P/Discharge Summary ☐ Therapy Notes (PT/OT/ST)
☐ Billing Records ☐ Operative/Procedure Reports ☐ Lab Reports/Pathology ☐ Progress/Clinic Notes
☐ X-rays Reports ☐ X-rays Films/MRI

☐ Other (specify content): ____

5. Please initial to authorize the release of all information related to the records below:

Psychotherapy Notes Information ________ __________ (initial) Alcohol and/or Drug Use Information ________________ (initial)

6. Date records are needed by: _____/_____/_____. *(Legal proof of identification is required for all requests.)*

7. Purpose: ☐ Personal ☐ Legal ☐ School ☐ Payment of Claim ☐ Continuing Care ☐ Workers Compensation

☐ Other (Please specify): ____

8. Disclosure Format: *(Paper is default)* If electronic, please indicate preference:

☐ Fax ☐ US Mail ☐ Verbal ☐ Electronic ☐ CD ☐ Flash Drive ☐ Other______________________

9. By signing this form, I understand the following:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to RLMC at the address above. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure by the recipient, and the information may not be protected by federal or state privacy regulations.
- Requests for copies of medical records may be subject to retrieval and photocopying fees in accordance with Mn statute 144.335.
- **This consent will end one year from the date the form is signed unless an earlier date or event is indicated:**

DATE: ____/____/____ EVENT: ____

______________________________ ______________________________
Patient Signature Date

______________________________ ____________ ____________________
Authorized Representative Signature Date Relationship to Patient *(if applicable)*