Authorization for Disclosure of Health Information

This is a request for sharing patient health information by and about:

______________________________	______-______-______
Patient Name (Last, First, Middle Initial)	**Social Security Number**

Street Address	**City**	**State**	**Zip Code**

______/______/______	(________) _______-___________	(________) _______-___________
Date of Birth	**Daytime Phone**	**Evening Phone**

Information to be released from:	Information to be released to:
Name of Clinic	**Twin Cities Occupational Health & Rehabilitation (TCOHR)**
Address	**2520 Pilot Knob Road, Suite 250** **Mendota Heights, MN 55120**
Phone / Fax	**Phone: 651-224-8264 / FAX: 651-224-8265**

Please disclose the following:

[ ] All Records pertaining to Occupational Health
[ ] Laboratory reports: date(s)_________________
[ ] x-ray films: date(s)______________________
[ ] x-ray reports: date(s)____________________

ALL RECORDS pertaining to psychiatric/mental health and/or HIV / HIV related illnesses will be released *unless* indicated here:
[ ] _________(initials)

THIS INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF:

[ ] Referral for Care [ ] Transfer of Care [ ] Social Security Disability Determination or Appeal
[ ] Legal / Litigation [ ] Insurance Application [ ] Insurance Claim or Payment
[ ] Other (specify)____

Authorization expiration date or event _______________ (if left blank, will expire one year from date of signature) NOTE: A fee may be charged in accordance with MN Statute 144.335 and Federal Rule 164.524

I understand that I may revoke this authorization in writing at any time except when TCOHR has already relied on this authorization. I understand that I may revoke this authorization by faxing a written notice stating my intent to TCOHR Center Administrator at fax # (651) 224-8265. A fax/photocopy/scan of this authorization will be treated in the same manner as the original.

Further, I realize that TCOHR cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore TCOHR is released from any and all liability resulting from re-disclosure. I have read and understand my rights.

______________________________________ ____________________________
Patient / Legal Representative Signature Date

____
Authority to act on behalf of Patient (attach document)