



**WESTHEALTH**  
outpatient health care

2865 & 2805 campus drive  
plymouth, MN 55441  
phone 763-577-7000

Medical Records: 763-577-7142 Fax: 763-577-7104  
Film Room: 763-577-7054 Fax: 763-577-7071 Medical Record#: \_\_\_\_\_

**Authorization to Release Protected Health Information**

PATIENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ Last 4 digits SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE# \_\_\_\_\_

I authorize WestHealth, Inc to disclose confidential medical information as specified below:

For ALL dates

From the following dates: \_\_\_\_\_ to \_\_\_\_\_.

To include:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Entire record  | <input type="checkbox"/> Operative report   | <input type="checkbox"/> Radiology films<br><i>Originals must be returned</i> |
| <input type="checkbox"/> Breast Center report   | <input type="checkbox"/> Pathology report   | <input type="checkbox"/> Radiology report                                     |
| <input type="checkbox"/> Urgent Care Lab results<br><i>All other lab results must be requested from the ordering physician.</i> | <input type="checkbox"/> Urgent Care report | <input type="checkbox"/> Other _____  |

This information is to be disclosed to \_\_\_\_\_

\_\_\_\_\_ for the purpose of:

**I understand that:**

- (1) This authorization is effective for one year from the date I sign below;
- (2) My medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse;
- (3) I can revoke this authorization, in writing, at any time, but my revocation will not apply to any information already released in good faith;
- (4) I can send a request for revocation or questions about disclosures to the Medical Records Department at the address listed above;
- (5) Once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure;
- (6) I can refuse to sign this authorization and still be assured treatment;
- (7) I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524; and
- (8) A photocopy/fax of this authorization will be treated in the same manner as the original.

**I hereby release the facility, its employees and my physician(s) from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information. Authorizing disclosure of my medical information is voluntary.**

\_\_\_\_\_  
Signature of patient or legal Guardian

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
If not signed by patient, identify relationship to the patient

FOR OFFICE USE ONLY  Mailed  Faxed  Patient picking up

Date Request Filled: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Filled by: \_\_\_\_\_

Type of ID & Expiration: \_\_\_\_\_