

# UNIVERSITY OF MINNESOTA

# MORRIS

*Simply an Excellent Choice*

University of Minnesota, Morris  
Health Service  
600 East Fourth Street  
Morris, MN 56267  
Phone: 320-589-6070  
Fax: 320-589-6161

## Authorization Form for Release of Information

Patient Name: \_\_\_\_\_  
Last First MI Maiden/Other Name

Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

### **I HEREBY AUTHORIZE TO RELEASE MY HEALTH INFORMATION**

FROM:  
Name: \_\_\_\_\_  
(person or clinic)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

TO:  
Name: \_\_\_\_\_  
(person or clinic)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Health Information to Be Released

I specifically authorize release of the following information:

- Entire Medical Record or (check appropriate boxes)
- Immunization Records only
- Most Recent Physical/Pap Exam
- Lab Results
- Other

Reason for Release of Information \_\_\_\_\_

### Conditions of Authorization

1. This Authorization will expire on: \_\_\_\_\_
2. I may revoke this Authorization at any time by notifying UMM H.S. in writing and it will be effective on the date notified.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected Federal privacy regulations.
4. I know I will not be penalized if I do not sign this Authorization.
5. I have been offered a copy of this signed Authorization form.

\_\_\_\_\_  
SIGNATURE OF PATIENT