



University of Minnesota, Morris
Health Service
600 East Fourth Street
Morris, MN 56267
Phone: 320-589-6070
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Authorization Form for Release of Information

Patient Name: _____
Last First MI Maiden/Other Name

Birthday: _____ 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

DATE