St Cloud Surgical Center
SPECIALISTS IN OUTPATIENT SURGERY

RELEASE OF RECORDS / AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION A: Must be Completed for all Authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released according to this authorization may lose the protections of federal privacy regulations due to re-disclosure by the recipient.

PATIENT NAME: _____ **DOB:**_____ **ID NUMBER:** _____

ORGANIZATION PROVIDING THE INFORMATION:

Please complete and submit request by MAIL OR FAX to:

St. Cloud Surgical Center
1526 Northway Drive
St Cloud, MN 56303
Phone 320-229-3231
Fax: 320-229-3202

PERSONS / ORGANIZATIONS RECEIVING THE INFORMATION:

Name : _____

Address: _____

City: _____**State**_____ **Zip**_____

Phone: _____ **Fax:** _____

DATE(S) OF SERVICE: _____

INFORMATION REQUESTED (Check all pertaining items):

_____ **Anesthesia Report** _____ **Discharge Summary** _____ **Entire Billing Record**

_____ **Operative Report** _____ **Pathology Report** _____ **Other:** _____

Purpose of the Use or Disclosure: _____

FORMAT REQUESTED (3 options):

_____ Mail _____ Pick Up at St. Cloud Surgical Center

_____ Email: _____
(By choosing this option, I acknowledge there may be security risks to my health information while in transit)

SECTION B: Must be Completed by the Patient or Patient Representative for all Authorizations

The patient or the patient's representative must read the following statements then sign where indicated:

I Understand That:

1) This authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law, including research related treatment which may be conditioned upon this authorization.
2) The authorization will expire on ___/___/_____ (fill in date if less than 1 year) or 1 year from date signed.
3) I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any action taken before receiving the revocation.
4) St Cloud Surgical Center may impose a fee to cover the cost of labor, copying and postage.

I understand that information released according to this authorization may lose the protections of federal privacy regulations due to re-disclosure by the recipient. Access to medical records may be subject to additional state and federal regulations for specific issues including but not limited to the following: HIV/AIDS, mental health, alcohol and substance abuse, minors, fees, industrial accidents, disability, birth defects, cancer, and genetic information.

_____ _____

Signature of Patient or Patient's Representative **Date**
(Form MUST be completed before signing)

Printed Name of Patient's Representative_____

Relationship to the Patient: _____